AN EXPLORATORY STUDY OF INFORMATION OBTAINED BY OBSERVATION IN THE HOME OF SELECTED PSYCHIATRIC PATIENTS

by

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A thesis submitted to the faculty of the University of Utah in partial fulfillment of the requirements for the degree of

Master

of

Science

Department of Nursing

University of Utah

August, 1960

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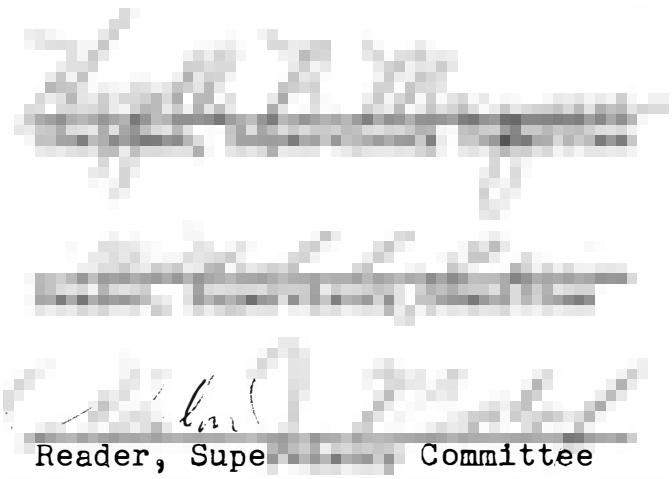

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ACKNOWLEDGMENTS

Sincere appreciation is expressed to Mrs. Hazelle B. Macquin, Miss Sumiko Fujiki, Mrs. Mildred Quinn, and Dr. Phelon J. Malouf, members of my supervisory committee for the encouragement, guidance and support which they have given me during this research effort.

Appreciation is extended to Dr. Nyla Cole, Director of the Utah Mental Hygiene Clinic, and her staff, with special thanks and appreciation to Dr. H. B. Fowler and Dr. G. L. Johnston, members of the clinic staff, for their cooperation and help in selecting the patient sample and analyzing and rating the research data.

Sincere thanks and gratitude are expressed to Miss Lena Besendorfer, Miss Sumiko Fujiki, Mrs. Mary Gorrow, Mrs. JoAnn Jedlicka, Miss Dorine Loso, Mrs. Ora Loy Robison, Miss Jane Stace and Mrs. Camilla Wood, who so graciously gave of their time to serve as the Psychiatric and Mental Health Nursing Experts for this study.

Sincere thanks and appreciation are extended to Dr. William H. Brown, Clinical Psychologist, to Miss Annette Wilson, my roommate, and to Miss Besendorfer, Director of Nurses of the Salt Lake City Health Department for their interest, understanding and support throughout the research and writing of

this project.

Special thanks are given to my typists, Mrs. Barbara Ralphs, Mrs. Ann Bushar, and Miss Mary Brown, without whose helpful assistance and cooperation the preparation of this report could not have been completed.

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CHAPTER I

INTRODUCTION

During recent years the trend in psychiatric patient care has been away from lengthy hospitalization in the isolated state hospital toward treatment of the individual in the home and community. The prognosis of many patients has been favorably influenced by use of the newer therapies, such as the ataraxic drugs, as well as by increased use of individual and group psychotherapy. It is now becoming a common practice to treat the acutely psychotic patient in a local community hospital, with plans for early discharge and follow-up therapy on an out-patient basis.[1] Many other seriously ill individuals who are not considered to be a threat to themselves or others in the community are treated in Day or Night Care Centers or with tranquilizers and psychotherapy while living at home. These patients are frequently encouraged to continue their regular activities as much as it is possible for it is felt that breaking the contact with the home, the job and/or the community may prolong the patient's

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[1]Nathan Beckenstein, "The Importance of Mental Hospital Aftercare Programs to Treatment," Mental Health Bulletin. (Michigan Society for Mental Health), XV (January, 1956), p.7.

illness.[2]

Although the family has long been considered of importance in the development and maintenance of mental health and in the predisposing and precipitating factors of mental illness, little has been done to study these factors systematically or to include the family in long-range plans for treatment. Dr. Nathan W. Ackerman, a leading proponent of family diagnosis and treatment, states:

> . . . The tendency to isolate conceptually the individual from his family renders prediction of the course of illness virtually impossible. The proper unit of prediction cannot be the person alone but must be the person-family environment as an integrated unit. The dynamic balance of individual and group influences the precipitation of illness, the course of illness, the possibility of recovery, and the risk of relapse. Yet the great importance of day-by-day family experience is all but ignored in much current practice.
>
> It is the failure to assess the environment or to achieve effective control of it that often limits the result of psychiatric treatment . . . . Individual diagnosis and therapy cannot alone deal with these difficulties (interpersonal and internalized conflict) or promote the kind of mental health that today's turbulent society demands.[3]

With the maintenance or early reintegration of the

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[2]Harvey J. Thompkins, "Modern Psychiatric Care," Teaching and Implementation of Psychiatric-Mental Health Nursing, (Washington, D. C.: The Catholic University of America Press, 1958) pp. 18-32; Hildegard E. Peplau, "Therapeutic Concepts," Aspects of Psychiatric Nursing, Section B, (New York: National League for Nursing, 1957), p. 30.

[3]Nathan W. Ackerman, The Psychodynamics of Family Life, (New York: Basic Books, Inc., 1958), pp. 10-11.

patient in the home, increasing emphasis is being placed on the importance of information about the relationships and interactions of the patient with family members and with others with a significant role in his immediate environment in order to provide more effective treatment and to assist the patient in the process of rehabilitation and resocialization. In regard to this, Ackerman says:

> . . . We are beginning to broaden our view and examine mental illness as an expression of the significant relations of the individual with his social group as well as the balance of internal psychic processes. In this sense mental illness can be examined at three levels: (1) what goes on psychically within one person; (2) what happens between this person and his human environment; (3) what is distorted in the social processes of the environment itself. . . .[4]

This idea is closely related to the philosophy of psychiatric nursing, and indicates that the home environment may be a pertinent area for study and function in regard to care of the mentally ill patient in the home environment. To date this area has largely been left untouched.

Psychiatric nursing has been defined by Kalkman as "an art by which the nurse helps her patient in every way available to her to become a socially well-adjusted human being,"[5] and Kremsdorf wrote that "the (psychiatric) nurses' area for

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[4] Ibid, p. 6.

[5] Marion E. Kalkman, Introduction to Psychiatric Nursing, (New York: McGraw-Hill Book Company, Inc., 1950), p. 7.

therapeutic effort (is one which) deals with environmental situations (both physical and social), immediate needs, and problems of attitudes, mood and feeling tone."[6] With the changing trend in psychiatry, it would seem that the psychiatric nurse has a unique function in the care of the patient at home. She has a need to evaluate and redefine her role in terms of this newer trend, the patient, his family, and the community. In order to do this, she must have a knowledge of the various elements in the home and community with which the patient is involved, and which may be meaningful both to the patient and/or the individual planning patient care. Since one of her roles has been defined as that of observer and recorder of the patient's behavior and interactions,[7] objective observation of the patient at home by the nurse becomes one step in obtaining such knowledge.

STATEMENT OF THE PROBLEM

Although the value of information about a patient in the home environment has been recognized, factors such as cost, lack of time, a fear of negatively influencing individual therapy, and difficulty in gaining admission to the home have limited the use of the home visit in psychiatry. Little

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[6]Doris Kremsdorf, "Redefining the Role of the Psychiatric Nurse," Nursing World, CXXV (March, 1951), 110.

[7]Kalkman, op.cit., p. 8.

research has been done to determine the significance or kinds of information obtained during such visits. The investigator had previously been impressed by the kinds of information about the home environment of a patient which were observable during calls to the home. It was inferred from this that observation of the psychiatric patient in his/her home setting by a skilled participant of the psychiatric team might provide information about the patient and his or her family which was significant to the psychiatric nurse and/or formerly unknown to the psychiatrist.

PURPOSE OF THE STUDY

The purpose of this study has been: (1) to determine the kinds of information about a psychiatric patient and his family that are available by observation of the patient in the home and/or work setting, (2) to evaluate the kinds of information obtained by such observation which are significant or meaningful to the psychiatric nurse, and (3) to determine the kinds of information obtained by such observation which are considered new and significant to the patient's therapist.

HYPOTHESIS

Observation of selected psychiatric patients in the home setting by a skilled observer will provide types of information about the patient and the family which are significant to the

psychiatric nurse and the psychiatrist in understanding the patient's illness and planning therapy.

QUESTIONS TO BE ANSWERED

1. What are the kinds of information obtained by observation of the psychiatric patient in the home?
2. What kinds of information obtained by such observation are significant to the psychiatric nurse in planning therapeutic patient care?
3. Is there information obtained by such observation which is considered by the psychiatrist to be new and significant in relation to therapy?

DEFINITIONS

For the purposes of this study, material presented as "information" is defined by: (1) the ability of the observer to observe and record objectively what went on in the home situation while she was visiting, (2) the number and kinds of incidents selected by the researcher for analysis, and (3) the areas selected by the psychiatric nurse experts who analyzed the incidents providing material about the patient in the home, The terms psychiatric and mental health nursing experts, "experts" or "raters," are used interchangeably in this study, and refer to nurses who have completed the requirements for a master's degree in psychiatric or mental health nursing and four have also had graduate experience in the field.

The terms "psychiatrist," "doctor" and "therapist" are also used interchangeably in this report, and all refer to the psychiatrist on the staff of the Utah Mental Hygiene Clinic who was seeing the patient in psychotherapy.

For purposes of this study, "agreement" during the first rating refers to the inclusion of a significant incident in a particular category by four of the five "experts." When three of the experts agreed on a category for an incident, agreement was considered to be questionable, but the incident was included for further study. If only one or two of the "raters" had placed an incident in similar groupings, the incident was classified as having "no agreement" and was deleted. "Agreement" on the second rating refers to selection of the same category for an incident by two of the three experts.

"Significant" in this study refers to: (1) the incidents about the patient and/or his family which were considered to be meaningful by the psychiatric and mental health nursing experts and (2) the kinds of information provided by these incidents on which there was agreement by the experts. When discussing the doctor's review of the information, "significant" refers to incidents or the kinds of information which were possibly rather "startling," provided new insights into the patient's problems or behavior, or validated a previously formulated but still questioned theory about the patient and/or family.

DELIMITATIONS

The method of observation was one in which the researcher's participation varied from minimal participation to an informal interview or a supportive type of role to the patient and/or family. The role varied in each family, with the amount of participation depending upon the situation at the time. The families were not aware that the observer was there for the purpose of obtaining information about the patient and family by observational methods. Therefore, some more active methods of participation were required. The reason for their lack of awareness will be discussed in Chapter III of the report.

The patients included in the study consisted of three female, diagnosed schizophrenic patients who were being treated in out-patient therapy, living at home with their families, and referred to the investigator by the Utah Mental Hygiene Clinic. These patients were each visited twelve times, one visit being at the place of employment and the remainder at home. The length visits varied from a few minutes to two hours, depending on the place of the visit, the receptivity of the patient and the family to the visit, and the time available for the visit on the part of the patient, the family, and the observer.

The kinds of information obtained by this investigation are limited by the facts that: (1) all three patients were

working and were home less often than are many women patients, (2) there were no adult male (husband and/or father) figures in the home during most of the observations since none of the patients were married at this time, and (3) the families of all the patients seemed somewhat reticent to participate in the conversation or to interact with the patient and/or observer, especially during the early visits by the investigator.

PREVIEW OF REMAINDER OF THE THESIS

In the remainder of this report, the author first attempts to present a review of literature (particularly previous studies) closely related to this study, and then to describe the methodology utilized in carrying out this particular study. The data obtained and its analysis is presented, suggesting the areas of information obtained by this method of research by a psychiatric nurse and presenting some examples of the incidents selected for analysis. The types of meaningful information as they were decided upon by the experts who examined and classified the data are discussed, as well as a summary of the therapist's review of and reaction to the information. The study is then summarized and suggestions made for future research related to this area of patient care.

CHAPTER II

REVIEW OF THE LITERATURE

A review of the literature indicated that few studies have been reported pertaining to information about or care of the psychiatric patient and his or her family in the home. Especially in nursing journals and psychiatric nursing textbooks there is a paucity of articles, studies or content material relating to this subject. In a review of twelve psychiatric nursing textbooks only one[1] mentioned the psychiatric patient in the home setting. The authors of this text described specific kinds of nursing care, such as giving medication and meeting the patient's physical needs. In relation to the family, they state:

> The nurse must be assured that members of the family will not interfere with her instructions from the doctor or with her own duties as a nurse. . . . (She) may do much to allay family fears, to reassure the patient and to foresee difficulties that may arise from the nature of the disorder. . . .[2]

With increased emphasis on interpersonal relations in psychiatric nursing, more attention is now being focused on the importance and relationship of the environment and the

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[1]Katherine McL. Steele and Marguerite L. Manfreda, Psychiatric Nursing (Philadelphia: F.A. Davis Company, 1950), pp. 483-486.

[2]Ibid, p. 484.

family to the patient's illness and recovery. Alice Behymer describes the affect of social living on the maintenance of mental health or the development of illness as she discusses patient care in the hospital.[3] In a discourse on "Social Science Concepts in Psychiatric Nursing," Simmons stresses the idea of the nurse utilizing sociological concepts with systematic observation and analysis in studying the family situation of the mentally ill patient in planning and providing therapeutic nursing care.[4]

Dr. Harvey J. Thompkins discussed modern-day psychiatric care and treatment at a Psychiatric-Mental Health Nursing Workshop in Washington, D. C., as a method of setting the stage for deliberation of the psychiatric nurses' role in service, training and research. In so doing, he said:

> In discharging our responsibilities as medical personnel we cannot limit our interest in the mentally ill to those found in the specialized hospital, public or

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[3]Alice F. Behymer, "Patient Care: Meeting the Needs of the Emotionally Ill Patient Through Nursing" Concepts of Nursing Care (The League Exchange, No. 26, Aspects of Psychiatric Nursing, Section A; New York: National League for Nursing, 1957), p. 1.

[4]Leo W. Simmons, "Social Science Concepts in Psychiatric Nursing," Concepts of Nursing Care (The League Exchange, No. 26, Aspects of Psychiatric Nursing, Section A; New York: National League for Nursing, 1957), pp. 54-60.

> private, but must include the psychiatric patient wherever he is found . . . .We are interested in the home from which he came and to which he may return. We are concerned with prevention and rehabilitation. Considering the information available in other fields of medicine, we have a very limited knowledge of the strength of our enemy and our own assets in discharging these responsibilities.[5]

In discussing one of the roles of the psychiatric nurse, Peplau comments that the focus is shifting from the physical aspects of the environment to concern over the social situations in which the patient is involved. She identifies observation and collection of data for sampling the interpersonal atmosphere in a family situation as one of the nurse's activities,[6] and suggests that one of her psychotherapeutic functions is "the study of interpersonal relations among groups of patients, workers, or family members and responsible intervention so as to promote changes favorable for all participants."[7]

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[5]Harvey J. Thompkins, "Modern Psychiatric Care," Teaching and Implementation of Psychiatric-Mental Health Nursing (Washington, D. C.: The Catholic University of America Press, 1958), pp. 21-22.

[6]Hildegard E. Peplau, Therapeutic Concepts (The League Exchange, No. 26, Aspects of Psychiatric Nursing, Section B; New York: National League for Nursing, 1957), pp. 13-14.

[7]Ibid, p. 3.

In another paper, this same author identifies another area of interest and function for the psychiatric nurse in interviewing patients in their homes before and after discharge from a psychiatric hospital, saying that:

> . . . .The staff nurse and the public health psychiatric nurse (mental health-public health) specialist have a role in helping people to recognize and solve interpersonal difficulties which otherwise may lead eventually to hospitalization; also assist the patient to use and strengthen his interpersonal competence in reintegrating himself into the family unit upon discharge from a hospital.[8]

The area of public health nursing has been more lucrative in providing research in regard to the patient in the home setting. One reason for this was stated by Marjorie Drake in reporting on the relationship of public health nursing to mental illness and mental health when she wrote:

> The (public health) nurse in the community mental health program is forced to keep the importance of the family group to the patient and the patient to the family group constantly in mind. She is the worker whose unit of service is the family and its members. . . . Her contribution is unique in that she continues to use the visit to the home as one of the tools through which her service reaches the family and its members.[9]

The majority of the articles or studies relating to public health nursing and the psychiatric patient are concerned with

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[8]Hildegard E. Peplau, "Principles of Psychiatric Nursing," American Handbook of Psychiatry, Vol. II (New York: Basic Books, Inc., 1959), p. 1853.

[9]Marjorie E. Drake, "Relationship of Public Health Nursing to Prevention, Treatment and Rehabilitation of Mental Illness and the Promotion of Mental Health," Concepts of Nursing Care (The League Exchange, No. 26, Aspects of Psychiatric Nursing, Section A; New York: National League for Nursing, 1957), p. 10.

the role of the nurse in providing patient and family care,[10] and little research has been done to study the discharged or out-patient who is living at home in relation to needs, problems of family relationships and environmental interactions.

One study, made by Ida Gelber as partial fulfillment of requirements for her doctoral degree (Ed.D.), investigated needs of patients who had been discharged on tranquilizing drugs, and related these needs to a public health nursing follow-up program. The basis for this study was the noted lack of follow-up care for psychiatric patients. This study did not concern itself with the other family members and the methods utilized in research did not include personal contacts with the patient himself or the family.[11]

Two major studies are presently being conducted, one

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[10]Mildred Kincade, "The Follow-Up of Discharged Mental Hospital and Clinic Patients," Reprint of a talk presented before the Mental Health Section at the Annual Meeting of the American Public Health Association, November, 1956; Florence A. Beasley and William C. Rhodes, "An Evaluation of Public Health Nursing Service for Families of the Mentally Ill, "Nursing Outlook, IV (August, 1956), pp. 444-449; Mary Anne French, "The Visiting Nurse in a Psychiatric Program," Nursing Outlook, IV (October, 1956), pp. 572-574; Marjorie E. Drake, op. cit., pp. 8-12.

[11]Ida Gelber, "An Investigation of Needs of Released Mental Patients on Tranquilizing Drugs in Relation to Recommending a Public Health Nursing Follow-Up Program" (unpublished doctoral dissertation, New York University, 1957).

by the American Nurses' Foundation, Inc.[12] and the other by Community Studies, Inc., [13] in which observational and recording methods are being utilized to look at nurse-patient participation while the public health nurse is visiting the patient in the home. The data obtained will be used to identify patterns of nursing care, to assess problems in the field of public health nursing, to look at differences in behavior in nurse-patient contacts, and to try to isolate variables which might influence or be related to different kinds of nursing care. Psychiatric patients are included in the patient sample in these studies. Here, too, the focus of the observations is on the nurse- patient interaction, with some emphasis on analyzing the data in relation to needs of patients and the role of the nurse in meeting these needs.

There are a limited number of on-going studies of diagnosis and treatment of entire families of psychiatric patients. One of these, described briefly by Marjorie Kvarnes, is a project being carried on by the National Institute of Health in which the entire family was brought to the hospital

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[12]Helen Simon, "Progress Report of a Research Project; Public Health Nursing Study of the American Nurses' Foundation," A talk presented at the Forty-first Convention of the American Nurses' Association, 1958.

[13]Peter Kong-ming New, "Report of a Study of Public Health Nurse-Patient Contacts," Report of a Nursing Research Conference (Kansas City: Community Studies, Inc., Publication II, March, 1958), pp. 77-78.

for study and treatment. In this setting, the nurse serves as an observer of family interactions as well as providing therapeutic intervention in situations where the need is indicated.[14] The results of this study have not yet been published.

Ackerman presents a framework for study of the family from which family diagnosis can be made.[15] This framework or guide was the outgrowth of a study in which the patient and family members were interviewed individually, were observed in interaction in the clinic setting and were observed during a two and a half to three hour visit to the home.[16] In discussing the need for this type of observation, he stated:

> Thus far studies of the ongoing process of mental illness have emphasized one-sidedly the effects of specific psychiatric treatment. But we must examine with equal care the concurrent environmental factors that influence the course of illness, in particular the matrix of ongoing family processes. . . .[17]

Clausen, et al, report the initial findings of an intensive longitudinal study being conducted by the Laboratory of Socio-environmental Studies, within the Research Branch of the National Institute of Mental Health, which is concerned

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[14]Marjorie J. Kvarnes, "The Patient is the Family" Nursing Outlook, VII (March, 1959), pp. 142-144.

[15]Nathan W. Ackerman, Psychodynamics of Family Life (New York: Basic Books, Inc., 1959), pp. 138-145.

[16]Ibid, p. 129

[17]Ibid, p. 90.

primarily with the perceptions and reactions of the wife to the mental illness of her husband.[18] The method utilized in this study was a series of intensive interviews with the wife of each patient based on an interview guide. The interviews were begun immediately after hospitalization and terminated usually about six months after the patient's discharge.[19] The research questions related to the wife's understanding of the illness, the effect of the illness on relationships in the family, the effect of illness on the wife's orientation toward significant others, and her attempts at reconstruction of the psychological future.[20]

Studies of psychiatric patients in the home setting utilizing direct observational and recording methods are limited. Behrens and Ackerman stress the necessity of home visits in obtaining information about the patient and utilized the method of participant observation in the home as one of the methods of determining the criteria for and formulating a family diagnosis in a study designed to establish such criteria, to classify the emotional functioning and mental health of family groups, and to find ways of correlating the pathology

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[18]John A. Clausen, et al, "The Impact of Mental Illness on the Family," The Journal of Social Issues, XI (1955, No. 4, entire issue) pp. 3-64.

[19]Ibid, p. 4.

[20]Ibid, p. 11

of individual members with the pathology of the family unit.[21]

In his book, "Patients Have Families," Henry B. Richardson describes an exploratory study of illness in families, looking at the family as the unit of treatment. A multiple discipline approach was used, with representatives from the medical, psychiatric, social work and nursing fields involved. The fifteen families selected for study were those with whom all the disciplines were acquainted and data was obtained by weekly conferences in which each person discussed his own observations in his routine functioning with the family. Observations of the family in the home were made by a public health nurse. The conferences were tape recorded and transcribed and the material was then used as a basis for generalizations about the impact of illness on the family, equilibrium of the family during illness and the responsibility of various disciplines to the family. As a result of this research, the author suggested that family equilibrium might be looked at in terms of: imitation, identification, dominance, focus, motivations, reciprocating systems, and integration with the culture.[22]

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[21]Marjorie L. Behrens and Nathan W. Ackerman, "The Home Visit as an Aid in Family Diagnosis and Therapy," Social Casework, XXXVII (January, 1956), pp. 11-19.

[22]Henry B. Richardson, Patients Have Families (New York: The Commonwealth Fund, 1946).

The studies previously discussed are all concerned with the patient and family in some way. However, each is geared toward the solution of a specific problem such as determining roles of personnel, selecting criteria for diagnosis, etc. Frequently the methods used were interview or single observations. In the interview method, the bias or concept of the interviewer may easily distort the validity of the information obtained. Single observations are apt to be influenced by the reaction of the patient and family to the visit of a researcher. These studies in which observational methods were utilized in the home setting did not describe the kinds of information obtained by this particular research tool, nor did they discuss in any detail what types of information were most apt to be significant.

With constantly increasing emphasis on the influence of social, environmental and interpersonal factors on the mentally ill patient, much additional research is needed to determine what these influences are, to study the present relationship of the patient to the family, to determine patterns of family interaction and behavior and to understand ways in which various methods of treatment and nursing care can best be utilized in assisting the patient toward recovery and more effective socialization. In order to develop specific research programs which are directed toward studying needs and problems of patients and family members, roles of various disciplines in relation to treating the patient and the family, studying

environmental factors which influence the patient's recovery, etc., it would seem that it is important to first gain some insight into what goes on in the home environment between the patient and the family and what kinds of information are available about the situation by observing the patient and family in the home setting.

CHAPTER III

METHODOLOGY

Because of the purpose and exploratory nature of this investigation, an "analysis of 'insight-stimulating' cases"[1] was the method selected by the researcher. In discussing this method, Selltiz, et al, stated:

> Scientists working in relatively unformulated areas, where there is little experience to serve as a guide, have found the intensive study of selected examples to be a particularly fruitful method for stimulating insights and suggesting hypotheses for research. . . .
>
> . . . .It should be clear that we are not describing what is sometimes called the "case-study" approach, in the narrow sense of studying the records kept by social agencies or psychotherapists, but rather the intensive study of selected instances of the phenomanon in which one is interested. The focus may be on individuals, on situations, on groups, on communities. The method of study may be the examination of existing records; it may also be unstructured interviewing or participant observation or some other approach.[2]

These authors described the three characteristics of this approach which make it an appropriate procedure for evoking insights as: (1) the attitude of the investigator, which is one of seeking rather than of testing; (2) the intensity of the study of each individual, group or community; and (3) the ability of the investigator to "draw together many diverse

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[1]Claire Selltiz, et al, Research Methods in Social Relations (Revised One-Volume Edition; New York: Henry Holt and Company, Inc., 1959), p. 59.

[2]Ibid, pp. 59-60.

bits of information into a unified interpretation."[3] In this study, the researcher hoped to seek for information by intensive study of a few patients and their families, and then to formulate categories which would identify the kinds of information obtained over a period of visits from a collection of incidents observed during each visit.

Originally the investigator was interested in determining if different kinds of information were available by observing the discharged psychiatric patient in the home setting than was obtained by interview of the patient and/or family in the hospital or clinic. (The idea that there might be some variations in such data was based on the investigator's past experience and belief that the bias and subjectivity of the patient and/or family members might distort or limit the amount and kinds of information reported during an office or hospital interview.) The data obtained by observation was to be compared with the patient's hospital record and reviewed by the patient's therapist in order to substantiate or repudiate the hypothesis. When the research design was completed and the desired patient sample was defined, it was indicated to the investigator by staff personnel from three psychiatric settings that some of the requirements of this design could not be met at that time. The problems encountered were that

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[3] Ibid, p. 60.

(1) patients who had been hospitalized were seldom seen routinely after discharge for follow-up therapy (unless referred to and treated by a private psychiatrist), (2) there was an insufficient number of patients from one hospital who met the sample requirements and were living at home and in a close enough radius for the researcher to visit, (3) records of the patients were apt to be so incomplete as to make their use as an accurate basis for comparison both invalid and unreliable, and (4) staff personnel indicated some reluctance to refer patients for this type of a study. For these reasons the investigator then changed the focus of the study to a determination of the kinds of significant information (if any) obtained by observation of the psychiatric patient at home (and work, if applicable).

Laying the Groundwork.

A brief pilot study was conducted during the time that the proposed patient sample was being selected and referred to the researcher. In this study, the homes of two discharged psychiatric patients who were not being seen in follow-up therapy were each visited twice. The observations were recorded in different ways and in order to select an effective method of observation, the general areas on which to focus the observations, the most appropriate method for recording the data, and some of the general kinds of information which might be

obtained during the investigation. At this time it was decided that the major focus of the observations would be the behavior of the patient and/or family members and interactions between the patient, other family members and/or others. It was also decided that the most productive method of collecting the data would be an immediate, and as complete as possible, recording of all the observations, using as much verbatim material as possible.

Selection of the Patient Sample.

The final patient sample selected for the study included three adult female, mentally ill patients who were living at home and were being seen in therapy at the Utah Mental Hygiene Clinic. These had not been hospitalized, but had been diagnosed as being very ill and needing intensive therapy. They were seen regularly on an outpatient basis, following a complete intake evaluation by a psychiatric social worker, and a psychiatrist or psychiatric resident. Two of the patients had received psychological testing by a clinical psychologist.

The number of patients selected was limited to three because of certain limitations on the investigator's time. The sex of the patient sample was based on the premise that the female patient would be more apt to be in the home at various times during the day and evening, which would provide more opportunity for rotating the time of the observations and

obtaining a wider range of data about daily activities and interactions of the patient and family. This premise later proved to be false.

Since schizophrenic patients frequently have difficulty in relating to others and in communicating with others verbally,[4] this diagnostic category was preferred. It was on the basis of difficulties with relationships and communication that the patient sample was selected, although they were not all diagnosed as schizophrenic.

The criteria for the patient sample was given to the head of the Utah Mental Hygiene Clinic and her staff, who selected four patients whom they felt most nearly met the criteria. Immediately following the referrals, the investigator made two visits to all of the patients with the idea of including the entire group in the study. However, one of the patients was living alone, was seldom at home when the visits were made (even at an appointed time), hesitated about admitting the researcher to her apartment each time she was visited (with two observations being made out of a total of five calls at the home), was not to be seen regularly in therapy, and said she planned to leave town the following month. On the basis of all of these factors, this patient was excluded from the sample group. In

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[4] J. S. Kasanin, Language and Thought in Schizophrenia (Collected Papers), (Berkeley, University of California Press, 1954), p. 63.

presenting data about the remaining patients, fictitious names will be used for identification purposes.

The youngest patient, Louise A., was approximately twenty years of age, unmarried, living with her mother on the outskirts of a small town about a half hour drive from the city and had been in therapy for over two years at the Clinic. The second patient, Betty B., was about thirty years of age, divorced, living with her three children aged seven, ten and eleven, and had been seen at the Clinic only for an evaluation. The third patient, May C., was around forty years of age, lived with three of her four children aged eight, fifteen and twenty, and the house included two male boarders in their late teens. May's husband had been deceased for about five years and her eighteen-year-old (and only) son was in the United States Air Corps. This patient had been seen in therapy for a prolonged period of time (over two years). It was interesting to note that in none of the homes was there an adult male (husband or father) figure living.

All of the patients were working during the day, so that the majority of visits had to be made in the late afternoon or evening. However, visits were made to each patient on her days off in an attempt to include a wider variety of data. One observation was made at each place of employment, which included a building materials store, a cafe, and a dry cleaning establishment.

An attempt was made to obtain a patient sample with a variety of family reactions to the patient's illness, ranging from interest and acceptance to an apparent lack of concern and/or rejection of the patient. The parents of the first two patients gave some evidence of being unaccepting of the illness and the patient's therapy. The family (parents and siblings) of the last patient appeared to be more accepting, but were not in the home situation and interactions between these family members were not observed.

The patients were prepared for the observer's visits by their psychiatrists, who indicated that a new program was being tried for a period of time in which a psychiatric nurse would visit the home several times to see the patient and family, and that the purpose of the study was to determine if this type of service would be beneficial in the care of the patient. Patients were also told that they would be given an opportunity to participate in an evaluation of this service when the study was completed by discussing their reactions to it. This fact proved to be influential in the kinds and amount of participation of the observer during the study.

Collection of Data.

At first the time of the visit was not scheduled with the patient. The investigator soon learned that this entailed making many calls which were not fruitful. On one such visit

the patient was at home, but was angry because she had not been expecting the observer. She requested that this not happen again. After several such attempts or experiences, the patient and investigator agreed on the time of the next visit before the latter left the home.

The frequency of visits was originally planned to be two or three per week for a four to six week period (to make a total of twelve observations). It was found by the investigator that the frequency of visits could not be closely controlled because of the patients' working hours and the limitations of evening time available for make the observations. The receptivity of the patients to the visits was also an important factor in planning the frequency, as they were at times hesitant about scheduling another appointment in less than a week. Because of these factors, Louise was visited twice weekly with the exception of two weeks when she had requested that the nurse observer not return for a week. Betty B. was seen two or three times each week and May was visited weekly (at her request) with the exception of two weeks in the latter part of the study when she was seen twice weekly. The total number of weeks the observations continued varied with thefrequency of visits, in order to obtain the total of twelve observations for each patient. Louise was seen over a period of seven weeks, Betty, over a period of five weeks, and May, for a period of eleven weeks. Tables reporting the time, length

and frequency of visits to each patient are included in Appendix A.

A problem was also encountered in attempting to make initial contact with the patient and/or family. On each of the initial visits the patient was not at home. A member of the family responded on the first attempt to visit one patient, another to the second, and six attempts were made to contact Mrs. B. before anyone was found at home. On each of these initial contacts with family members, the observer was not invited into the home and the observations consisted largely of a description of the house and neighborhood, and of a brief conversation with the family member who responded.

The primary method used in collecting data for this study was that of participant observation. Schwartz and Schwartz define participant observation as:

> . . . .a process in which the observer's presence in a social situation is maintained for the purpose of scientific investigation. The observer is in a face-to-face relationship with the observed, and, by participating with them in their natural life setting, he gathers data. Thus, the observer is part of the context being observed, and he both modifies and is influenced by this context. The role of participant observer may be either formal or informal, concealed or revealed; the observer may spend a great deal or very little time in the research situation; the participant-observer role may be an integral part of the social structure or largely peripheral to it.[5]

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[5]Morris S. Schwartz and CharlotteGreen Schwartz, "Problems in Participant Observation," The American Journal of Sociology, LX (1954-1955), p. 344.

Jahoda, et al, have stated that although this type of observation "which is especially indicated for exploratory purposes, has most often been used to explore large social units, such as entire cultures or communities, . . .it is also appropriate for the exploration of small groups about which so little is known that more systematic procedures would be out of place."[6]

In this investigation, the amount of participation during each observational period varied with the situation. It was interesting to note that early in the study the family members remained in the room with the patient and observer very little, possibly due to their lack of understanding of the basic purpose for the observer's visits and to some feeling of being threatened by being visited and observed by a member of the psychiatric team. At times, the type of participation with the patient became that of an unstructured interview in which the investigator was primarily a "listener." During most of the visits, the observer participated largely in a supportive role to the patient and/or family members.

The limits set on the types and extent of the research data were based primarily on the ability of the researcher to observe, to recall, and to record the observations objectively after leaving the home or work setting. In order to make this data more reliable, the researcher set certain limits and used

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[6]Marie Jahoda, et al, Research Methods in Social Relations, Part I: Basic Processes (New York: The Dryden Press, 1951), p. 133.

certain controls during the study. These included the following:

1. The observer did not review the patients' records or discuss their cases with the therapists before beginning the study. In one case (Betty B.), the observer had some contact with the therapist during the study as the patient was suicidal and twice called the investigator to ask about obtaining medication or being admitted to the hospital. At these times, the investigator tried to refrain from asking for or obtaining information from the therapist which might influence her observations.

2. The same observer made all of the visits to collect data, which limited the variables of bias and difference in perceptions which might result from including a number of observers in the investigation.

3. To help maintain the objectivity of the observer, three methods were used. The first of these was immediate complete recording of the observations. Jahoda, et al, states that "A full record of interviews and observations is as important in maintaining the objectivity of the researcher as in providing research data."[7] The second method was to discuss the observations regularly with three other psychiatric nurses, which helped the observer to become aware of and consider her

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[7]Marie Jahoda, et al, Ibid, (Part II, Selected Techniques), p. 511.

own biases and to recognize instances in which she was becoming too closely identified with the patient. For the third method, an additional psychiatric nurse accompanied the investigator on a visit to two of the patients. The observations of both were recorded and compared for variation in the kinds of material observed and recorded, and the amount and kinds of interpretation included in each report.

4. The investigator attempted to record the observations objectively, including much verbatim material and with a minimum of interpretation.

5. One problem encountered by the observer was the limited time for recording the observations after leaving the patient's home. Recognizing that this was an important factor in the study, a portable tape recorder which could be used in the car was obtained. The data was then verbally recorded immediately after the termination of the visit. This method of recording proved to be very valuable to the investigator as she could also replay the recordings and pick up inflections in her voice, words, interpretation, etc. which provided clues to her own feelings and attitudes as well as to her perception of the behavior of the patient and the family.

6. Throughout the study the observer attempted to be aware of her own feelings, attitudes and reactions to situations in order to minimize the influence of the factors on the observations.

7. The investigator attempted to wear clothing and make-up, and to adapt her speech and manner of approach in ways which would be appropriate and unobtrusive so that these factors would not be instrumental in influencing the behavior or interactions of the patient or the family.

The transcriptions of the tape recordings provided a mass of raw data from which many individual incidents were selected for study. The investigator attempted to select both often repeated and unique incidents which had been observed during her visits. Because of the tremendous amount of data, it was found that a limit to the number of incidents included must be set before having the data sorted and analyzed by the group of psychiatric and mental health nursing experts. There was originally over three hundred incidents in the initial selection. At this time the investigator found that a decision had to be made regarding whether to include the majority of incidents observed during the visits to two of the patients, or to include a more limited number from all three. It seemed to the investigator that editing the items from all would introduce more subjectivity in the matter of individual selection of incidents and the decision was made to delete all of those observed during the visits to one patient. Since the observations of May C. had provided less variety of information and more duplication in the incidents, these incidents were deleted.

In order to determine the significance and kinds of information obtained during the study, the incidents to be included were placed on individual five-by-eight cards and sent, with instructions for sorting and a personal letter describing the study, to seven psychiatric and mental health nursing experts. The definition of "expert" as used in this study is given in Chapter I. These experts were asked to sort the incidents into two piles, those they considered significant and those they did not. They were then asked to sort the significant incidents according to some basis of similarity so that all of the incidents included in a group seemed similar in some way, and to label each group as to what they felt the similarity was. Comments regarding the individual or groups of incidents were encouraged. Five of the "experts" completed the rating of the incidents. The other two sets were returned unsorted with explanatory letters. The first stated that pressures of her immediate work situation did not allow the nurse time to complete the sorting. The last "expert" commented that she had been unable to find any meaningful way to sort or classify the incidents. She felt that if the entire situation had been included, a more complete picture would have been evident which might have enabled her to draw some meaningful conclusions.

On the basis of the five ratings, the investigator deleted all incidents which were considered to be "not significant" by three or more of the experts. Their groupings

into areas of similarity of incidents were used as a basis for identifying and defining categories for the kinds of information suggested by the data, and were placed by the researcher under the category which seemed to best include or describe them. The number of times an incident was included in a category (because of inclusion in the experts' areas of similarity listed under that category) was determined by tabulation and was used as a basis for determining "agreement" as to the kind of significant information which they felt this incident provided.

To establish the kinds of information obtained, the incidents which were considered significant and on which there was agreement or questionable agreement and a list of the defined categories were sent to three additional psychiatric nursing experts. They were asked to categorize each of these incidents according to the type of significant information it provided, if any. (See Appendix C.) Validation of a single incident for providing any one kind of information was based on agreement of rating by at least two of the three raters.

The incidents were also given to the patient's psychiatrist, who marked each according to the category in which he felt it belonged, whether the information provided by it was previously unknown to the psychiatrist, and whether or not he considered it to be meaningful or significant to him. As

was previously mentioned, in this instance "significant" designated information which might be rather startling, provide new insights or substantiate a previously formulated idea about the patient and/or the family.

Statistical analysis of the data was not attempted since it was considered to be inappropriate due to the size of the patient sample, the limited number of raters, and the nature of the investigation.

CHAPTER IV

DEVELOPMENT OF THE CATEGORIES

Psychiatric and mental health nursing experts assisted in the development of the categories by determining the significant incidents, and by indicating what there was about these incidents that made them significant. On the basis of their suggested groupings of significant, similar incidents, the investigator selected categories to identify the kinds of information which had been obtained and which would be significant to psychiatric nurses in relation to the psychiatric patient.

Presented in this chapter will be the description of these categories, the way in which the information included in each was perceived as significant by each of the raters in naming their groupings, the total number of incidents seen by one or more nursing experts as providing this kind of significant information in each category, and the number of incidents on which there was "agreement" by three or more of the raters. The variety of data which might be included in each of the categories is identified with the significance of this information as it relates to increased understanding of and planning care for the psychiatric patient by the nurse and the psychiatrist.

Rating and classifying was completed on five sets of

incidents. The resultant groupings were used as a basis for determining significance of the incidents and for selecting categories which might identify the kinds of information collected during the investigation.

The number of items classified as "not significant" by each of the raters ranged from zero to forty-one, with a mean of 23.2. The number of incidents so rated by the individual experts was: 0, 11, 28, 36, and 41. Any incident identified as not being significant by three or more raters was deleted from the remainder of the study. Nine of the items fell in this category. Twenty-three others were seen as "not significant" by two of the experts, and many of these were later excluded because of lack of agreement between the remaining raters as to the kind of information they provided. (Table I, page 109, reports the numbers of the items considered insignificant.

There was a range of from five to fifteen groupings (areas of similarity of incidents) suggested by raters. Eight groupings were named by two of the raters and ten by a third. The mean of the number of suggested groupings was 9.2. All of the experts indicated that they felt these groupings could have been broken down into smaller areas, or that the incidents

might have been analyzed to determine the dynamics of the situations included in the incidents. They felt that the lack of specific direction for sorting or "what the investigator wanted" made the process a very difficult one. The length of time for completing this analysis by each expert varied from approximately four and one-half to nine hours. Table VII, page 165, lists the kinds of groupings suggested by each of the five experts and the number of incidents included in each. The identification number given each of the experts indicates the sequence in which the data was returned, and will be utilized throughout the remainder of the study whenever reference is made to an individual rater.

Using the named areas of similarity which were suggested by these experts as a basis, the investigator selected the categories which might identify the kinds of information obtained during visits to the patients' homes. Referring to the problems of categorizing information, Heyns and Lippitt state:

> (One) sense in which the term postcategorization is used . . . refers to the practice of developing the category system in the process of studying some sort of total record. . . .The initial step is typically that of deriving the categories in part at least from the behavior itself. At various times in the sequence, categories are added or dropped on the basis of what types of behavior appear and can be differentiated. There are, therefore, times in the life history of most observation schedules when they are essentially postcategorization systems. Indeed, any system which purports to be applicable to a wide variety of social situations must have that sort of history if its

> claim to such generality of use is to have any validity at all.[1]

In determining the kinds of information obtained in this study, the investigator attempted to use broad categories which she felt might be mutually exclusive (would not overlap), but which would be inclusive of the kinds of information seen by the experts in their analysis of the data.

The areas of information most frequently identified by the first group of raters included: (1) the patient's (a) self-concept, (b) needs, problems and conflict areas, (c) interpersonal relationships with family members and other individuals (including the nurse observer), and (d) work adjustment; (2) the attitudes and relationships of other family members toward each other and outsiders; and (3) socio-economic and environmental factors. These areas were used as the basis for selecting the majority of the categories and setting their limits. In the process of identifying these categories, the investigator found that some of the groupings suggested by the raters were very broad and inclusive, while others were quite narrow. This proved to be an important factor in determining the incidents on which there was "agreement" as to the kinds of information they provided. An example of this was seen in Category IX,

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[1]Roger W. Heyns and Ronald Lippitt, "Systematic Observational Techniques," Handbook of Social Psychology (Vol. 1, Gardner Lindzey, Editor, Cambridge: Addison-Wesley Publishing Company, Inc., 1954), p. 399.

which relates to the patient's work situation. Only three of the five raters named this as a separate area. These three were not in complete agreement on any of the incidents they identified as relating to this area, although two of the three did agree on most of them. All of the incidents so identified were deleted from the study because they did not meet the necessary criteria for "agreement."

In some instances, two separate groupings listed by a rater were incorporated into a single, broader category. This especially was true for Category III, which pertains to the patient's needs, problems and conflicts, and his attempts to identify and work through these. Two areas named by each of four raters were placed within the single framework of this category since a comparison of all the groupings indicated overlapping between these eight.

One category, Number X, was included on the basis of identification by only one expert. Two others, Numbers XI and XII, were added because of the investigator's personal theory that such information was obtainable and significant. A more detailed discussion of each of the twelve selected categories is presented below. The areas of information as named by each rater are listed by number of the rater under the category into which they were incorporated.

Category I. Physical and socio-economic environments of the patient and family.

The importance of socio-economic status to the American individual has provided the impetus for a number of recent studies relating to mental illness and social environment. For example, Hollingshead and Redlich investigated the problem of correlation between social stratification and psychiatric disorders. These researchers came to the conclusion that:

> . . .There are definite connections between the particular types of social environments in which people live, as measured by the social class concepts, and the emergence of particular kinds of psychiatric disorders as measured by psychiatric diagnosis.[2]

Information about the physical and socio-economic environment is frequently indicative of social class and therefore provides clues to some of the patient's environmental stresses and may be suggestive of social values and social relationships of the patient and/or family members.[3]

This category includes descriptive data of the physical appearance of the patient's home and the neighborhood in which the family resides. Referred to throughout the remainder of this report as "Socio-economic" information, it might also provide clues to the patient's background, the ability and/or

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[2]August B. Hollingshead and Frederick C. Redlich, "Social Stratification and Psychiatric Disorders, "Mental Health and Mental Disorder, Arnold M. Rose, Editor (New York: W. W. Norton and Company, Inc., 1955), p. 134.

[3]Jerome K. Myers and Bertram H. Roberts, Family and Class Dynamics in Mental Illness (New York: John Wiley and Sons, Inc., 1959), pp. 247-262.

interest of the family in maintaining socially approved and culturally accepted environmental "standards," and the adequacy and use of family income.

The areas of similarity between incidents which were identified by the experts and were incorporated in this category by the investigator were:

Rater 1 - Incidents which might provide clues of the socio-economic status of the patient of the type of environment from which he or she emerges.

Rater 2 - Significant in evaluating the physical appearance and setting of the home.

Rater 3 - General background.

Rater 4 - Environmental background. Socio-economic factors involved.
Feelings regarding area in which one lives and how one reacts to these factors.

Rater 5 - Incidents reflecting the setting or environment in which the patient and family live.

There was "agreement" on eleven incidents out of a total of thirteen placed in this category by one or more of the raters, and these were included in the second rating.

Category II. Patient's concept of self and feelings about self in relation to others.

Stevenson and Sheppe define self-concept as the "set of thoughts which the patient has about himself."[4] In discussing

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[4]Ian Stevenson and William M. Sheppe, Jr., "The Psychiatric Examination," The American Handbook of Psychiatry, Silvano Arieti, Editor (New York: Basic Books, Inc., 1959), p. 224.

the importance of self-concept, Bingham Dai indicates that (1) each patient seeking treatment seems constantly preoccupied with what kind of a person he is; (2) all self-concepts seem to have definite socio-cultural referent situations; (3) patients frequently have conflicts of roles or self-concepts, but each individual constantly strives for a consistent self-picture which he considers appropriate to his present socio-cultural environment; (4) a change in behavior is often found to follow a change in self-concept; and (5) changes in self-concepts frequently result from changes in relationships between the self and others.[5] Information included in this category provides insight into the patient's level of self-esteem, his feelings of adequacy, inferiority, guilt, and anxiety, and the way in which he sees himself in relation to or compared with other family members, friends etc.

Following are the groupings as they were named by the raters which were suggestive of and included in this category:

Rater 1 - Incidents which might provide clues to nurse of the patient's deepest, most subjective kinds of feelings.
Patient's level of self-esteem.
How patient views self in relation to others.
Patient's sense of inadequacy.

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[5]Bingham Dai, "A Socio-Psychiatric Approach to Personality Organization," Mental Health and Mental Disorder, Arnold M. Rose, Editor (New York: W. W. Norton and Company, Inc., 1955), pp. 316-317.

Patient's feelings of guilt and self-recrimation.

Rater 3 - Self-concept or feelings for self.

Rater 4 - Self-concept.
Fear and Anxiety about illness - insight?

Out of a total of ninety-five incidents which were included in this category by at least one expert, there was "agreement" on fourteen.

Category III. Patient's needs, personal problems and conflicts, and the way in which he is attempting to work through and resolve these.

Symonds states that psychological or sociological conflicts may be expressed behaviorally through such manifestations as strong unpleasant emotion, excitement, restlessness, tension or withdrawal. Observation of such behavior may provide indications of the basis for and way in which the patient tries to deal with or resolve the conflict.[6] Insight into conflict areas of the patient provides a major focus for psychotherapy and for therapeutic nursing intervention when providing patient care.

In reference to needs of patients, Schwartz and Shockley state that:

> . . . in attempting to fulfill their needs, patients will reveal their inner conflicts, their distortions,

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[6]Percival M. Symonds, The Dynamics of Human Adjustment (New York: Appleton-Century Crofts, Inc., 1946), pp. 340-351.

> their suspicions, their distrust, and their anxiety. . . He works out a pattern of communication (verbal and non-verbal), which is his way of drawing attention to his needs. The pattern may not be the most appropriate ones, but the nurse must discover and understand it in order to work out appropriate ways of meeting his needs.
>
> The nurse's function is to understand the patient's needs, to understand his feelings about them, and to try to fulfill them in an appropriate way.[7]

This function of the nurse indicates the importance of data which will assist her in identifying the patient's needs and an appropriate way of meeting them.

The information included in this category provides clues to the patient's personal problems, conflicts, and expressions of and attempts to meet his physical and emotional needs such as need for nourishment, shelter and warmth, financial security, love and affection, recognition, and acceptances. It also includes data relating to the patient's insight in these areas and the way in which he is attempting to identify, work through, and resolve these conflicts and problems.

Classifications selected by the experts which were utilized for the first test of this category were:

Rater 1 - (a) Incidents which might provide clues to nurse of the deep feelings and expressions of need for some recognition, acceptance, and love, with some indication of what the patient might be

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[7]Morris S. Schwartz and Emmy L. Shockley, The Nurse and the Mental Patient (New York: Russell Sage Foundation, 1956), p. 229.

doing to obtain these.
(b) Incidents which might provide clues that the patient's problem may be emanating from some religious conflict.

Rater 2 - (a) Situations indicating concern or possible stress areas in relation to psychosexual development.
(b) Significant in determining the patient's attempts to identify personal problems and attempts to work toward some understanding and/or acceptance of.

Rater 3 - Religion.

Rater 4 - (a) "Work" relationships - "testing-out" and maturing.
(b) Value system - regarding behavior. Religious involvement and belief.

Rater 5 - (a) Significant data of expressed concern and anxiety on part of patient in relation to:
Her effect on children or her concern about them.
Anxieties around moving and not being able to get settled.
Problems of finances.
(b) Significant data in relation to religion and patient's conflicts and values.

Twenty-six incidents were found to be significant and in "agreement" for providing this kind of information, out of one hundred seventeen items which were marked as significant in this area by one or more raters.

Category IV. Patient's relationship with family members(marital partner, parents and siblings).

The importance of the relationship between the patient and other family members in the prevention or precipitation of mental illness is receiving increased recognition. Ackerman,

in discussing patient and family roles and interactions, states:

> It is useful in a basic sense to think of the family as a kind of carrier of elements predisposing both to mental illness and mental health.
>
> . . . If the psychiatrist exerts himself to inspect the relations of the primary patient with other family members, he will be rewarded with some cogent information . . . .[8]

And Ian Stevenson commented that "Only by entering into his daily life, as it were, can we come to appreciate the subtle but cumulatively powerful relationships between the patient and others close to him. And usually such an appreciation will permit us to dissect the respective contributions of the patient and those around him to the strain he experiences."[9]

Those areas defined by the first group of experts which were included in this category were:

Rater 1 - Incidents which might provide clues to the nurse about state of patient-family relationships and possibility of problems arising in this area.
Patient-parent relationship.
Feelings of love, rejection, hatred, guilt (in relation to these relationships).

Rater 2 - Significant in evaluating patient's interpersonal relationships with family.

Rater 3 - Patient-parents relationship.

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[8]Nathan W. Ackerman, Psychodynamics of Family Life (New York: Basic Books, Inc., 1958), p. 104.

[9]Ian Stevenson, "The Psychiatric Interview," American Handbook of Psychiatry, Vol. I, Silvano Arieti, Editor (New York: Basic Books, Inc., 1959), p. 198.

Rater 4 - Patient-parent and family relationships.
Rejection, dependency, acceptance.
Interplay of family relationships.

Rater 5 - Significant in area of family relationships.
Mother.
Father.
Other family members.

There were thirty-one significant incidents in "agreement" for providing information about "patient-family relationships." A total of eighty-one incidents were identified by one or more of the experts as contributing this kind of information. However, one expert included patient-family and patient-child relationships in one grouping. Following the investigator's division of this into two categories, certain items tabulated only once in Category IV on the basis of this grouping were placed in the separate "patient (parent)-child" area by some or all of the other four raters. This factor may have influenced the number of items agreed upon as providing significant information in each of those areas.

Category V. Patient's attitude toward child-rearing attitudes and practices, and his/her relationships with children.

Studies on the epidemiology of psychiatric disorders frequently point to some correlation between the parent-child relationship and the incidence and type of mental illness. Most of these investigations have not been conclusive, due to a limitation in the sample population, the lack of a control

group, or other factors. Nevertheless, the weight of the evidence points to some relationship between the unconscious motivation and overt behavior of the parents and the emotional difficulties of the child.[10]

Concern about parent-child relationships and the prevention of mental illness, as well as a need to understand the patient's attitudes, conflicts, values, and ability to relate to children for the purpose of planning therapy, indicate a need for observation of the parent-child interaction, a discernment of attitudes of each toward the other, and an evaluation of the relationship between them. Investigation of this area early in treatment of the patient (whether parent or child), with psychiatric intervention when necessary, might prove to be a valuable control in the "spread" of mental illness. Although it is a common practice in child psychiatry to involve one or both parents in therapy simultaneously with the child, little has been done to study the affects of the parent's illness on his/her children, of the children on the parent's illness, or to provide therapeutic intervention when this is indicated.

In looking at information relating to the patient-child

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[10]John P. Spiegel and Norman W. Bell, "The Family of the Psychiatric Patient," American Handbook of Psychiatry, Silvano Arieti, Editor (New York: Basic Books, Inc., 1959), pp. 114-125.

relationships and child-rearing attitudes and practices, much of the focus should be on the patient's feelings about his/her children (such as feelings of adequacy, guilt, fear, concern, inadequacy, and anxiety), and on such attitudes as acceptance, rejection, overprotection, resentment, hostility, and aggression.

Areas of similarity listed by the raters which were used as a basis for defining this category were:

Rater 1 - Incidents which might provide clues to nurse about state of patient-family relationships and possibility of problems arising in this area.
Patient-son and/or daughter relationships.
Expressions of inadequacy as a parent.

Rater 3 - Patient-child relationships.

Rater 4 - Parent (patient)-child relationships.
Focused primarily on parent - "Am I a 'good,' wholesome, worthy parent?"

Rater 5 - Significant data in relation to patient (parent)-child relationship.
In regard to discipline and authority.
In regard to mother's concern re: health of child.
In regard to other children.

The experts were in "agreement" on twenty-six incidents, out of forty-eight selected by one or more raters, as providing significant information in patient (parent)-child relationships.

Category VI. Patient's relationship with individuals other than the immediate family.

The extent and depth of relationships between an individual and others in his community may be indicative of

maturity, and of mental health or mental illness. Changes which are seen in socialization patterns at times become manifestations of the degree of disturbance and/or recovery. In a study reported by Lita Adler, participation of former patients in both the formal and informal social life of their community was considered as one aspect of their readjustment.[11] In discussing "Social Role and Personality," Ackerman wrote:

> In the process of adaptation, the social role of the individual may serve either a positive or a negative psychological function. In mature, well-integrated personalities, a social role can reflect the strength of the individual expressed positively in participant group action. Here there is no conflict between the individual and the social components of self. They are mutually reinforcing. In weaker persons, handicapped by specific emotional disabilities and generalized immaturity, the individual and social aspects of self may come sharply into conflict. The effort of integrating a particular social role may exact an excessive price in terms of anxiety and conflict within the individual self; or conflict within the individual may damage or prevent the effective execution of a given social role.[12]

This category was selected to provide information which would assist in evaluation of the quality and quantity of the patient's relationships with those other than family members, such as peers, neighbors, and friends. The areas named by the psychiatric and mental health nursing experts which were

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[11]Lita M. Adler, "Patients of a State Mental Hospital: The Outcome of Their Hospitalization," Mental Health and Mental Disorder, Arnold M. Rose, Editor (New York: W. W. Norton, Inc., 1955), pp. 512-514.

[12]Ackerman, op.cit., p. 61.

incorporated in evaluating this category were:

Rater 2 - Incidents meaningful in area of interpersonal relationships with individuals other than the immediate family.

Rater 3 - (a) Patient-other relationships.
(b) Patient-"husband" relationships.

Rater 5 - (a) Significant in peer relationships.
Other girls and women.
Men.
(b) Data related to social relationships within neighborhood.

Forty-eight of the incidents were identified by one or more of the experts as relating to this area, and of these only six were found to be in "agreement" for this category. The investigator felt one of the reasons for this might be that two of the five raters did not list groupings which seemed to relate to "patient-other relationships." A grouping named by one rater ("patient-'husband' relationships") seemed to have only "face validity" for this category when compared with categorizations by the other raters, as none of the incidents included in this particular grouping were placed in a "relationship" grouping by the other four experts.

Category VII. Patient's relationship with the nurse observer.

Recent concepts in psychiatric nursing, as well as in all nursing, are stressing the importance of the relationship between the patient and the nurse in providing therapeutic nursing care. Brown and Fowler speak of an effective relationship as one "in which the nurse and patient find a common

ground and respond to one another."[13] They identify four phases in the development of the nurse-patient relationship and emphasize the necessity for the nurse to examine and evaluate what is happening between them in order to formulate and carry out thereapeutic nursing care plans.[14]

According to Schwartz and Shockley, "The nurse's aim is to provide opportunities that will help the patient grow emotionally. She attempts to nourish and to expand the 'healthy' part of the patient so that his emotional difficulties are less disabling. . . ."[15] It is the minute-to-minute relationship nurses or others maintain with a patient in an immediate situation that improvement in patients comes about.[16]

Although the purpose for visiting the patients in this study was not to develop a nurse-patient relationsip, it became evident to the investigator and the nurse observers who had accompanied her on a visit that this kind of relationship had been established with the patients. In selecting the incidents

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[13]Martha M. Brown and Grace R. Fowler, Psychodynamic Nursing (Philadelphia: W. B. Saunders Company, 1954), p. 116.

[14]Brown and Fowler, Ibid, pp. 107-113.

[15]Schwartz and Shockley, op.cit., p. 245.

[16]Ibid, p. 249.

from the raw data, many which provided information about this relationship were excluded as the observer's primary interest was the home and family environment of the patient. However, this kind of information is of major importance to the nurse whose function is to provide nursing care.

This category is designed to include information about patient behavior when relating to the nurse, patient-nurse interactions, and the nurse's feelings about the patient and herself during these interactions. When complete data is included in this category, the nurse should be able to examine the relationship so as to determine the current phase, the deterring or enhancing factors, the needs which are being expressed by the patient in this interpersonal situation, and an appropriate plan for nursing care.

The classifications of the experts which identified information about this relationship were called:

Rater 2 - Incidents meaningful in examining interpersonal relationships of nurse interviewer and patient.

Rater 3 - Nurse-patient relationship.

Rater 4 - Nurse-patient relationship.
Reaction toward "therapist."
Resistance.
Withdrawal.

Rater 5 - Significant in area of nurse-patient relationship.

There were eighteen incidents on which there was

"agreement" in the initial evaluation of this category out of sixty-five which were included in a "nurse-patient" grouping by one or more of the experts.

Category VIII. Family members' relationship among selves and with others (excluding the patient) and the attitudes each convey.

The attitudes of other family members and their relationships among themselves and with others, as well as with the patient, may be important in understanding the etiology and progress of the patient's illness. The destructive effects of extreme anxiety may shift from one individual family member to another and many times it has been found that the psychiatric illness of one individual represents the need of one or more of the other family members to protect themselves.[17]

The way in which a family copes with its problems and conflicts varies with its social status and cultural position. Some are able to maintain a semblance of conformity to community requirements and in social relations, while others may exhibit severe social pathology for a time.[18] Information about the attitudes and interactions of other family members, if obtained objectively and studied dynamically, may provide a better

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[17] Ackerman, op.cit., p. 102.

[18] Ibid, p. 100.

framework within which to understand the patient's conflicts, problems and ways of relating to others, and on which to plan therapy which will enable the patient to grow emotionally.

The areas of similarity listed by the raters and included in this category of information were:

Rater 2 - Family's interpersonal relationships among selves and with others.

Rater 3 - Nurse-family relationship.

Rater 5 - Significant parental attitudes about themselves or reflective of their own value system.

There was a great deal of diversity among the general groupings of the raters as they were incorporated in this category. Only four incidents were found to be in "agreement" following the first tabulation. This number was out of a total of twenty-three included in the original ratings by one or more of the experts.

Category IX. Patient's work adjustment and work performance.

"Fundamental to adequate social adjustment is the ability to carry on a life task. For most adult men this means engaging in a gainful occupation; for women it may mean either homemaking or employment outside the home."[19] In studying the relationship between occupation and major mental disorders, Frumkin found

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[19]Adler, op.cit., p. 508.

that there was some relationship between prevalence and type of mental illness and occupation. A high incidence of mental illness was found among low-income, low-prestige and low-socio-economic-status groups. Occupational prestige seemed to be more significant to mental health than did income.[20]

Work regularity, stability of employment, punctuality in arriving at and leaving work, job performance, attitudes toward the type of work and employment situation, ability to relate to other employees, and job satisfaction would all be criteria for determining the patient's work adjustment. Some information about these factors could be obtained by interview, but all might be more objectively evaluated by an on-the-job observation. These are the types of information the "work adjustment" category was designed to include.

Three of the raters identified groupings which were related to the patient's work.

Rater 2 - Significant relative to identifying problems re: economic security. Judgment in work performance and money management.

Rater 3 - Work.

Rater 5 - Significant observations re: patient and work adjustment.

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[20]Robert M. Frumkin, "Occupation and Major Mental Disorders," Mental Health and Mental Disorder, Arnold M. Rose, Editor (New York: W. W. Norton and Company, Inc., 1955), pp. 158-160.

Of twenty-one significant incidents which were placed in the "work" groupings by one or more raters, none were agreed upon as providing this kind of information.

Category X. Patient's interests and hobbies.

Although little has been written specifically about the importance of determining the patient's hobbies and/or interests, the investigator felt that this information would be valuable in several ways. English and Pearson stress the importance of "play", which they describe as a kind of antithesis to work, as an important factor in the maintenance of total physical and mental health, and in developing healthy family relationships.[21] Interests and recreational activities might be indicative of the individual's mental health.

Many of the behavioral scientists have discussed the development of interests (as well as vocational choice) as a result of gratification and frustration of needs. On the basis of this concept, discovery of the patient's interests and hobbies might provide more depth in understanding the dynamics of his/her behavior.

In the area of psychiatric nursing, knowledge of the interests of the patient may have special value. Render and

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[21] O. S. English and G. H. J. Pearson, Emotional Problems of Living (Revised and Enlarged Edition, New York: W. W. Norton Company, Inc. 1955), pp. 389-391.

Weiss discussed this first from the standpoint of developing the nurse-patient relationship:

> The interests you have in common with the patient help to establish sympathy, reciprocation, interdependence; they provide a meeting place for thought and discussion and reduce the patient's feelings of isolation. They become bridges of confidence. . . .
>
> The most effective point in common is the patient's interest of the moment. Awareness of this provides a constant opportunity for gaining rapport, for being subordinate at the right time, for increasing the patient's wholesome feeling of importance. . . .[22]

They also emphasized searching for interests of and for the patient since they felt that: "Interest motivates the patient to think and act in relation to reality, thereby redirecting energy from attention to symptoms into healthy channels."[23]

Information in this category would identify expressed interests and hobbies of the patient and his attitude toward and extent of participation in these. It would also include behavioral or verbal clues, indicating a possible interest of the patient which might be explored with the patient or used as a basis for motivation.

This particular area of similarity was mentioned by only one rater, and was described as:

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[22]Helena W. Render and M. Olga Weiss, Nurse-Patient Relationships in Psychiatry (2nd Ed., New York: McGraw-Hill Book Company, Inc., 1959), p. 94.

[23]Ibid, p. 95.

Rater 5 - Meaningful in relation to patient's interests and hobbies, such as sewing, drawing, taking course at university, etc. Also interest in church attendance.

This rater indicated seven incidents which she felt provided this kind of information. Since hers were the only incidents in Category X following the first data analysis, there was no "agreement" on any of them for this category.

Category XI. Patient's and family's reaction to stress and to "crisis" situations.

For purposes of this study and in reference to the term as it is used in naming Category XI, "stress" refers to both internal emotional turmoil and to pressure in the environment which is being or could be exerted upon an individual. A "crisis" is considered to be an externally created (physical, environmental or socio-economic) crucial point or emergency.

Jahoda suggests that resistance to stress and resilience are indicative of mental health or illness,[24] and Leighton, et al, mention the frequently accepted proposition that sources of stress are a major cause of mental illness. They suggest that in order to assess experiences which are labeled "stressful" by an individual, one would have to have objectively obtained "successive packages of data, secured through longitudinal, not retrospective study," to determine the sequence of objective

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[24]Jahoda, op.cit., pp. 90-91.

evidence of stress, perceptions of stress by the individual, and behavioral manifestations.[25]

Data obtained in this category might provide information about such a sequence, as well as resistance to stress, behavioral reactions, and ability of the patient and/or family to cope with stress and to meet and handle crises.

There were no suggestions as to this kind of information having been identified by the original group of raters. This may have been due to a lack of this kind of information in the data, an inclusion of it in another grouping (such as relating to conflicts), or a difference in perception as to what a particular incident "told" about a patient. The investigator felt that information about the way in which the patient and family reacted to stress and crisis was important, could be obtained by observation of the patient in the home, and might have been included in the data obtained for this study. This category was therefore added for possible validation by the second group of experts.

Category XII. Patient's and family members' attitudes and relations to pets and inanimate objects.

This is the second category which was not identified

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[25]Alexander H. Leighton, et al, Explorations in Social Psychiatry (New York: Basic Books, Inc., 1955), p. 136.

by any of the original group of raters, and the significance of this kind of information has seldom been discussed in the literature. Witenberg, et al, stated that:

> Man has to be related to things and to people in order to live. . . .
>
> Fromm sees living as following two kinds of relatedness to the outside world - that of acquiring and assimilating things, and that of relatedness to people. The orientation by which the individual relates himself to the world is the core of his character. . . .[26]

Certain kinds of behavior in relation to objects might be examined dynamically to determine such factors as stages of development at which "fixation" took place,[27] defense reactions as a result of difficulty in relating effectively with people, and the importance of symbols of social status or prestige.

Recently there has been more interest in the relationship of individuals and families to their pets. Nelson Foote stated that he felt the dog was the most neglected member of the family as far as studying human behavior. He continued with:

> . . . If we view human personality as process and product, it exists in an individual entity only on the retrospective; projectively, predictively, it is always emerging out of interaction between self and significant others. And to repeat, the most significant others in

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[26]Earl G. Witerberg, et al, "The Interpersonal and Cultural Approaches," American Handbook of Psychiatry, Vol. II, Silvano Arieti, Editor (New York: Basic Books, Inc., 1959), p. 1429.

[27]Symonds, op.cit., pp. 192-197.

> one's development are the members of his family, among which the dog has been neglected to the loss of understanding.[28]

The limitation of literature on this subject in itself indicates that it might be an area of interest for observation and further study. Through behavior patterns some individuals have shown greater ability to relate to pets than to humans, others have seemed to displace their hostility or fears onto them as is seen in animal phobias. This suggests that investigation of the way in which a patient and members of his/her family relates to pets or other animals might provide significant information about dynamics of personality, etiology of illness, behavioral patterns, interests, or conflict areas.

Information included in this category would focus on attitudes toward, and depth and kinds of relationships (such as warm, hostile, or protective) of the patient and/or family to inanimate objects and pets which are a part of their environment. This, in turn, might provide another basis for understanding dynamic factors such as: social values, needs, former patterns of gratification, and defense mechanisms.

Preview of Final Evaluation.

To further evaluate the categories which have just been

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[28]Nelson M. Foote, "A Neglected Member of the Family," Marriage and Family Living, XVIII (August, 1956) pp. 213-218.

described, the significant incidents on which there was "agreement" were sent with a list of the categories to three additional psychiatric nursing experts. Final determination of the kinds of information which were significant to the psychiatric nurse and were obtained by observation of the psychiatric patient and his/her family in the home was based on "agreement" as to categorization of incidents by two of the three additional experts. Information which was considered to be "new" and "significant" to the patient's psychiatrist for therapy was based on his reaction to and report of a study of all of the incidents. The following chapter presents the findings of the final ratings by the psychiatric nurses and the psychiatrists.

CHAPTER V

FINDINGS OF THE STUDY

This chapter is devoted to a presentation of the kinds of information which were obtained by observation of the psychiatric patient in the home and which were perceived as significant for gaining understanding of the patient and for planning patient care by a group of psychiatric and mental health nursing experts and by the patient's therapist. It also presents an empirical analysis of the findings of this study in relation to the significance, scope and content of each category of information.

The findings of this study are presented in two parts. First, each category and the kind of information observed and included are discussed. The numbers of the specific significant incidents which were found to be in "agreement" for each category of information following the final rating by the nurse experts will be presented in Table I, p.109. Examples of these incidents and a sampling of the incidents considered to be "new" and significant" to the physicians, along with comments made about these by each group, are presented in this portion of the report. Second, a discussion

of the differences between ratings by the nursing experts and the psychiatrists, and of the limitations of the findings of this study are given, along with some inferences and assumptions about these which were made by the investigator. During the home visits, certain general observations were made about factors relating to the visits which have not been researched in this study. These, too, are briefly mentioned here.

Evaluation of the Data.

Of the original 212 incidents included from the raw data for study, 137 were considered to be significant and in agreement by the first panel of psychiatric nurse experts, and were re-rated in the second evaluation. At this time, 11 additional incidents were deleted because of lack of agreement. The remaining 122 provided the basis for the following evaluation.

In reviewing and rating the incidents, the psychiatrists marked a total of 157 of the 212 incidents as providing "new" (previously unknown) and/or "significant" information. There are some differences in the use of the term "new" by the two physicians. Patient A (Louise) had been in therapy for over two years. Therefore "new" information had the connotation

of noteworthy information about the patient or family which was formerly unknown to the psychiatrist and which might be important to therapy. Patient B (Betty) began treatment at the same time as the observer's visits, and her physician was not as well acquainted with her background. Many of the incidents rated as "new" provided the doctor with unknown background information about the patient and her relationships with others, especially her family. This information in itself was not necessarily either startling or extremely important in planning treatment, but was considered to provide the psychiatrist with a better understanding of the patient and her conflicts and problems.

Doctor A. selected 56 incidents from the observations of Louise A. as being "significant" information to him. Four of these, plus 19 additional incidents, also were rated as presenting "new" information. Seventy-five of the 105 incidents selected from observations of Betty B. and her family were rated as being previously unknown to Doctor B. He commented that he felt most of the incidents provided meaningful information, since all behavior is purposeful and all information about a patient has meaning. In the frame of "significant" as it was used in this study for the psychiatrists' evaluation of the incidents, a total of thirty-four of the incidents referring to patient B. were so rated. Seven of these were substantiating information already

known, the other twenty-seven were marked as providing insight or "startling" kinds of information about the patient. Table II, p.110, lists the incidents found to be "new" (previously unknown) and those which were "significant" to the psychiatrist in relation to planning therapy.

Although the ratings of both the psychiatric nurse experts and the psychiatrists are discussed under each category, these ratings are not considered to be comparable. This form of presentation was used merely to facilitate discussion. At times, similarities or differences are discussed with an empirical analysis of some of the reasons for variations in rating by the two groups. The fact that the psychiatrists were well acquainted with the patients, whereas the nursing experts were not even provided with background information about the patients or their families, prevents any realistic comparison between the ratings of the two disciplines.

In rating the incidents the doctors underlined or indicated the portion of the incident which was considered by them to provide the "new" and/or "significant" information. When such was done, the underlining and comments are copied in the examples in order to indicate what there was about the incident that was important to the doctor and was the basis for categorization as to the kind of information presented.

Category I. Patient's physical and socio-economic environment.

Twelve incidents were found to be in "agreement" for providing this kind of information in the ratings by the psychiatric and mental health nurses. These specific incidents were descriptive of the exterior and interior physical appearance of the home and neighborhood in which the patient lived, the racial components in her neighborhood, and the inadequacy of her income. Illustrative of the significant incidents included in this category were the following:

Incident No. 2 - The nurse was invited into the front room of the A. home. It is a medium size room with a dull figured carpet on the floor. There is one window in the room. Beside the window is the front door. A couch is in front of the window, with a lamp beside it. The tops of the piano and cabinet were covered by a number of family pictures, one of the patient, one of her brother, one of her sister, wedding pictures of the sister and a married brother and pictures of their children. Along one wall is an overstuffed chair, a television set, a gas furnace, and a door leading into the kitchen. A door leads into the patient's bedroom on the south. Between this door and the front door is a treadle-type sewing machine with a straight-back chair in front of it. The room was clean and neat, the furniture was old but well cared for. In a large, clean kitchen was a big wooden table, a coal stove, a big sink and drainboard, a refrigerator and two or three chairs. (This incident was also rated as "significant" by the doctor, and the statement which he felt provided the significance has been underlined.)

Incident 108 - The B. family lived in a small apartment in a flat-roofed, one-level, five-unit, green stucco building. All of the units faced the street and opened onto a cement porch. In front of the porch was a waist-high concrete partition. Six square pillars supported the front of a roof which extended over the porch. The building was dirty and the paint was chipped. The front yard was partially covered with lawn, and there were bits of paper and old newspapers

scattered around. There was a dirty, electric, wringer-type washer in front of the C. apartment. The front porch was dirty and there were small piles of dry leaves under the washer and near the C's front door. (This visit occurred in March.) The units opened to a dirty yard in the rear, with a few shrubs and plants next to the building and a long clothesline behind it.

Incident 109 - The building in which the patient lived was surrounded by vacant lots. The nearest house was a block away, and there was an industrial plant two blocks away. Each of the apartments in the building were about the same size. Mexican families, each with four or five small children, were occupying two of the units. There were seven children in the family living next to the patient, and the mother of this family was pregnant.

Incident 203 - Betty said, "John said he doesn't care at all about money - that this isn't important to him. He says it all the time. But I can't understand that." There was a pause. "I - well, don't most people want to have - or am I just different? I - well, I'd like to have enough for the things we need. It seems like there just isn't ever any and the children need things all the time. I worry about it because I don't have enough."

In classifying these incidents as "significant," one of the mental health nursing experts commented that she felt the picture of the physical environment as depicted in this data provided significant information about family integration, social values, and the extent of health or illness of the patient or family. This, she felt, would be of importance to a nurse visiting the home, or in the hospital setting, in understanding the background and present socio-economic situation of the patient and family.

Eight incidents were classified by the psychiatrists as providing "new" and/or "significant" information about the

patients' physical and socio-economic environment. Of these, five (Incidents 108, 122, 165, 200, 201) were rated as "new" information by Doctor B. The remaining three were taken from observations of patient A. Two of these (Numbers 1 and 2) were rated as "significant," the other as providing information which was "new." The latter incident is shown below, with the new information underlined.

Incident 4 - After showing some dress patterns to the nurse and returning them to her room, Louise left the bedroom door open. There was a double bed next to the door with a pink spread on it. Across from the bed was a dresser with several small boxes stacked on top of it. There was an open closet in the corner by the dresser with several articles of clothing hanging on hooks and many articles of clothing on hangers. The room was neat and clean. <u>There was no decoration in the room - no pictures were visible to the nurse</u>. There was also a table with a portable sewing machine on it and a straight-back chair visible to the nurse. (Underlined as "new" and "significant" by Dr. A.)

<u>Category II</u>. Patient's concept of self and feelings for self in relation to others.

Fourteen significant incidents remained in this category following evaluation by the three psychiatric nurse experts. On none of these was there complete agreement (by all three experts), and only on three was the agreement for this category correlated with "agreement" for this same kind of information on the previous rating.

Incidents providing information about the "self-concept" were descriptive of the patient's behavior as she talked about herself, her appearance, her activities, the "reasons" for

situations which had occurred in her relationships with others, and her anxiety about the visit of the observer. Representative of these incidents were:

Incident 8 - Since moving into the city, and living directly over the nurse's apartment, the patient has attended both "Sunday School" and "Sacrament Meeting" in the Church each Sunday. When the nurse asked if she would like to do some art work for her Church, Louise said, "Oh, I don't know. I don't think they need an artist here, do they? I'll bet they have so many already." Her face flushed slightly at the suggestion, she twisted her hands and her body seemed quite tense. Then she added, "I think I'd just kind of like to go for a change." ("Significant" - Underlined by Dr. A.)

Incident 56 - Louise sat on straight-backed chair during the nurse's visit. She looked down throughout the conversation, glancing at nurse only twice. Hands held in lap were moving almost constantly. Occasionally rubbed eyes with fingers. Commented one time that she was "shaking" because she was "so frightened." ("Significant" - Underlined by Dr. A.)

Incident 106 - The patient said, "I feel like I'm really immature and that I'll never grow up - like I'm so much younger than others my age. Can you ever make it up when you don't have a chance to grow up when you're young?" She commented about being extremely ill as a child and asked if it was "normal" for children to have convulsions. "They used to tell me that I got convulsions all the time when I'd get sick. And I was wondering" - there was a slight pause; she flushed and looked down. "Well, when a child has convulsions does this do anything to them? Keep them from - well, make them different some way? I mean so that they can't grow up as fast or something?" She commented that her parents didn't believe in doctors, were afraid of doctors and didn't like her to take medicine. She thought that they really had helped her when she had hay fever. She said she didn't dare tell her mother if she went to a doctor and he gave her medicine because her mother was afraid sulfa "or any kind of medicine just about would kill me." ("Significant" - Underlined by Dr. A.)

Incident 114 - Betty asked about the possibility of obtaining Thorazine or a similar type of medication because

she felt "so confused" and was unable to think or sleep. "I feel so mixed up about everything - how it happened and all." She said she had known "this man" for a long time, but had "ignored him" until a few weeks after the death of her grandmother. "I feel like I have to do something about the situation now because I'm afraid that - I don't want to become ill again."

In regard to the significance of the "self-concept" incidents to psychiatric nursing, the raters felt that the patient's verbal and nonverbal behavior (especially when similar kinds of observations were repeated) were indicative of the patient's level of self-esteem, feelings of inadequacy and guilt, and her need for and ability to establish a good (growth-promoting) relationship with others.

In rating the seventeen incidents which provided information about the patient's self-concept and feelings for self, the psychiatrists selected fourteen as being "significant" and three as being both "new" and "significant." A majority of the incidents providing this kind of information were from observations of patient A. The first three previously given examples were illustrative of some of these. Two additional examples of data which provided this kind of information are listed below:

Incident 89 - After discussing her fears about moving, Louise said that she really could tell that she was feeling a lot better since she had started seeing Dr. A. She said, "I feel this has really helped a lot and I can see changes in myself, although I still feel awfully immature and like I have a long way to go. I really want to get married and yet I wonder if I ever will be able to. Sometimes

I'm afraid I won't - that I'm not and never will be ready. And I get so angry so easy - just over little things. Sometimes I get scared because I get so angry." Again two or three times she commented about the fact that she felt she was much more mature than she had been when she first started therapy. "I feel I can do a lot more things myself and for myself, but sometimes it's still hard." (Underlined as "new" and "significant" by Dr. A.)

Incident 128 - Jean came home from school and went into the bathroom. Betty watched her, then said, "Jean is doing better at school this year, although it's hard for her - harder than Shirley. And she really likes her Sister (teacher). She's decided she wants to be a Nun when she grows up. And she wants to go to Scotland to be a Nun." She paused for a minute, then added. "That's what I had been thinking about doing. When the children were grown, I wanted to enter a convent. It seemed like it would be ideal." She looked down. Tears came into her eyes. "But of course that's out of the question now. I couldn't - ." She stopped abruptly, paused, then changed the subject. (Indicated as "new" and "significant" by Dr. B.)

(For the numbers of all of the incidents in this and the other categories, refer to Table II, p.110.)

A number of differences were seen between the nurse experts and the doctors in selecting those incidents which they felt pertained to this category (provided significant information about the self-concept of the patient and related to dynamics of behavior). On the basis of the nurses' comments and the lack of complete agreement by the nurse raters in regard to this kind of information, the investigator has inferred that the incidents included in the study may have been too broad or included more than one kind of information. Therefore, the kind of information which was perceived as important in any one incident to each individual expert would have been

the basis for her rating. This would have influenced the number of incidents on which there was "agreement" as to the kind of significant information included, as well as the category which might have finally been selected for any one incident on which there was agreement by the psychiatric and mental health nurses.

Category III. Patient's needs, personal problems and conflicts, and the way in which he is attempting to work through and resolve these.

This category had the second greatest number of incidents which had been evaluated as providing significant information of the kind specified. Nine of the twenty so rated were in complete agreement on the second rating. The others had been agreed upon by two of the three raters.

Observations assigned to this category by the raters were descriptive of situations in which the patient was discussing: her feelings about herself and her religion (importance of attendance vs. inactivity, what is "right" or "moral" vs. her behavior, etc.); difference between her own and parents' ideas, desires, values, etc.; relationship with (dependency on) her mother; fears of inadequacy and desire for independence; needs, behavior and guilt in her relationship with a married man; problems relating to moving; need for acceptance; reaction to taking medication (or having medical care); and her feelings about her children and their

reaction to her (effect of her illness on their relationship, discipline, or behavior).

Incidents illustrative of the data providing information about the patient's conflicts, needs, and personal problems which would be significant in planning patient care designed to provide therapeutic nursing intervention and appropriately meet the patient's needs were:

Incident 69 - Louise said she had been to a doctor because of having an infection and he had given her some medication. "I didn't tell mother about the sulfa because she took it once and it made her sick. She said it would make me sick too. She and my father don't believe in doctors. He says they're all no good and just out to get your money. But mother stands up for them sometimes. But she is afraid to go to them, and doesn't like it very much when I go." (Underlined as "significant" by Dr. A.)

Incident 104 - Louise discussed fears about moving away from home, stating that she had a feeling that she shouldn't move, but that she only had this feeling when she was at home with her mother. "Whenever I'm away, like at work, I don't feel afraid and I'm quite anxious to move." She said she felt guilty about leaving her mother "alone out there like this," and also felt afraid because "Mother keeps telling me I won't be able to do anything without her. I already feel so inadequate, I'm really afraid. Maybe she's right. I just don't know how it will be when I move. My brothers and sisters feel that I should move - that it would be better for me if I do. It helps to know that they feel this way." (Underlined as "significant" by Dr. A.)

Incident 186 - Betty mentioned John only once and that was to say that she felt she had to see him, even though she had told him she couldn't see him again. "I don't really understand what the need is, but it's there. I almost called him today, and I kept wishing he would come into the cafe. But of course he didn't." (Indicated as "new" and "significant" by Dr. B.)

Incident 199 - Betty said, "I went into the Church and lighted a candle. It's the first one I've lighted for

months. And I prayed - I honestly and sincerely prayed - that something would go right. You know, to find a - a house, and then to-to have John make a decision or help me to make one - All week I prayed, but -" There was a slight pause, "There was nothing. I - I felt nothing, and nothing has happened. And then I wondered. I really and truly wondered. And I just don't know." There was a long pause and then she changed the subject. (Indicated as "new" and "significant" by Dr. B.)

Twenty-nine incidents (four of which have just been listed) were identified by the physicians as containing new or significant information in the area of needs, conflicts and problems of the patient. Two additional examples not in "agreement" for any kind of information by the nurse experts on the first sorting as to the kind of information presented are given below:

Incident 88 - Louise said she "is afraid of many things, and sometimes I get upset with myself for being so afraid." She described an incident which happened when she was a child in which their dog had been hit by a car. She felt that the driver had deliberately tried to hit the dog because he had swerved toward it as he drove along. The driver didn't stop. "I saw the accident happen and saw the dog move afterward so I knew it was still alive. But I wasn't to move the dog out of the way of the traffic because I was afraid it might bite me. Then another car hit the dog and killed it." Louise stated that she felt very guilty about this - that she had not been able to carry it off the highway - and had never been able to tell anyone about it before because of the guilt feeling. (Underlined as "significant" by. Dr. A.)

Incident 163 - Betty mentioned that J. had made "some big plans" for the week and said, "This bothers me. It really bothers me. This is a real important week for our Church and it's important for the children because of school and everything. The children participate and I feel like if they are, I need to participate too. It's important that they should see me - that I should at least make an effort and that they should see me doing these things. I feel that

if something is going to be important to them and if I want it to be important - and I do - then I should be there taking part so that they can see me do this. This really seems like the right thing to do even if it is hard, because I think children should feel that their parents - well, that they believe and practice those things too. And now J. has things that he wants me to do with him, and I just don't know - " There was a pause, and then she said, "I really want to do this. And then, too, I hoped that if I did - well, that maybe some of the feeling would come back. The belief, you know, and - well, that maybe I'd start finding an answer." (Indicated as "new" and "significant" by Dr. B.)

In discussing the significance of the data relating to patient B, the psychiatrist stated that the incidents presented more of the conflict which the patient had felt in relation to religion, to her children, to her mother, and to John, than had been indicated to him in therapy. She had centered the therapy hours a great deal on the need to "get out of" her relationship with John, and on the way she was feeling (desire to withdraw, anxiety about illness, etc.), and had not discussed the ambivalence she was feeling in regard to these relationships. As a result of this, certain basic problem areas (such as these incidents illustrate) had not been presented by the patient.

Category IV. Patient's relationship with family members (parents and siblings).

The psychiatric nurse raters selected sixteen incidents which they felt were significant for providing information about the dynamics of the relationships between the patient and her family. All of these were also marked as

significant in this area by the original group of experts. Many of the incidents were descriptions of direct interaction (or lack of same) between the patient and parent(s), and were indicative of the kind of relationship between them. There were also situations in which the patient discussed the relationship of her parents to each other, her feelings about them, and her parent's reaction to her illness. Only one of the incidents (Number 39) with final agreement as to significance for this category was illustrative of the patient's relationship with siblings.

The following are samples of the kinds of incidents about one patient which provided "patient-family" data significant to the psychiatric nurses.

Incident 11 - Louise talked a little about other family members. She said her father is working and living in a small town about 25 miles away and that she does not see him very often, "and I'm glad about that because I don't like to be around him anyway." She planned to look at an apartment "in a few days," and said her brother was going to try to find someone for her to live with. Mentioned fear of trying to live with someone she didn't know, but did not discuss it very long. (Underlined as "new" and "significant" by Dr. A.)

Incident 15 - The nurse was walking toward the house and Mr. A. was working in the garden beside the path. Louise hurried out of the house toward the nurse. She did not look at her father as she went past him. He glanced at her, then away, then watched as Louise and the nurse walked back to the car. (Underlined as "new" by Dr. A.)

Incident 49 - Mrs. A. and Louise were in the front room watching television ("The Rifleman") when the nurse arrived. Mrs. A. answered the door, then again sat on the

couch. At one time she commented, "I like to watch this show because the boy is so well behaved. He really knows how to be thoughtful and courteous and he always minds so well. I don't like to watch some of them because the children never do as they're told." She looked directly at Louise, then glanced at the nurse as she said this. Louise glanced at her, smiled slightly, looked down, then at the television again. She did not say anything. (Underlined as "new" by Dr. A.)

Incident 52 - Mrs. A. did not look at or speak to Louise as she walked past her twice. Two other times she entered the room and spoke to the nurse, but did not speak to Louise. (Underlined as "significant" by Dr. A.)

Incident 115 - Betty met the nurse in front of her parents' home and asked if they could go "away" to talk. She said that she could not talk about things in front of her parents. (Indicated as "significant" by Dr. B.)

One of the experts commented after the rating that she could see a "pattern emerging" which seemed very indicative of the problems between this patient and her parents, and that the relationship observed here would provide significant clues to the dynamics of the patient's behavior and ways in which the nurse might respond therapeutically to this behavior.

The psychiatrists indicated that one of the most important areas in which information was obtained by observation in the home was in relation to the patient's relationship with her parents. In both of the cases included in this study, it was indicated by the physician that the information about the father, especially, was new and important. In neither case had the patient discussed her father to any extent in therapy. Patient B. had never mentioned her father at

all. Illustrations of the incidents considered by the psychiatrists to be "very significant" are:

Incident 16 - Louise was discussing her feelings about moving. She said that both of her parents were upset about this move, that her mother cried all the time and even her father started to cry. "He gets real emotional. And I just left. When mother gets upset and starts to cry, then I feel really guilty that I shouldn't be leaving her alone out here. And I get afraid that I can't do it. I don't like my father and I'm really glad he hasn't been here much, because he and mother just fight all of the time. I don't like to be around them, and most of the time I just try to get away from them." (Underlined as "very significant" by Dr.A.)

Incident 71 - Louise was talking about moving, "This is sure going to be a terrible week. I sure don't look forward to it. Mother will be upset and crying all the time. Since I'm going to be moving on Friday, the nearer and nearer it gets the harder and harder it's going to be. Mother said she knew something would happen to me with all those terrible men who are out to get the girls, and she said that one day the police are going to lock up all those terrible men." Louise looked at the nurse and said quickly, "That's what she said. She says things like that all the time." As she spoke she folder her arms and her body was tense. The nurse asked if her father was upset, and Louise said, "Oh, yes, he's been real upset. He started to cry this morning. He gets real emotional. And I just left." (Underlined as "new" and "very significant" by Dr. A.)

Incident 202 - Mrs. D. came into the room, looked into her bedroom (where the bed was unmade), turned to Betty and said, "Couldn't you even make my bed?" Betty replied, "He (Father) didn't get out of it until noon - just before Miss H. came." Mrs. D. had already walked out of the room. Betty looked at the nurse and said, "I guess I should have had it made. Now she'll really be upset." She then turned and looked toward the kitchen and did not say anything for about five minutes. (Indicated as "new" and "significant" by Dr. B.)

Category V. Patient's attitude toward child-rearing attitudes and practices and his/her relationships with children as these are significant for planning patient care.

The largest number of incidents which were in "agreement" as to the kind of significant information they provided fell in this category. These twenty-five observations were all obtained during the home visits to Betty B., and a total of twenty-one were in complete agreement for this category on the second rating.

For the most part, these were descriptive of observed interactions between the patient and one or all of her children. A few were comments relating to the children's association with neighbors, her concern about the children's behavior, and her feelings about factors which are important in their development.

From incidents such as the following, the raters stated that they could "feel" the patient's conflict and guilt in regard to the children, her concern about them, and her inability to show warmth to them. They felt that the children's emotional reactions to this relationship and their problems were also evidenced in the data, such as their frequent ignoring of her requests or demands and Jean's need to"collect everything."

Indicative of the kinds of incidents which provided significant information of this type were:

Incident 123 - Jean ran into the house, crying and said that a neighbor child had pushed her down and was teasing Jimmy. Betty said, "Stay away from them. I've told you to

stay away from those children. Just don't go near them." Her voice was deep, her words short and clipped. She turned to the nurse as Jean left the house.

Incident 124 - Betty said, "I don't like the children to play with those others. Some of the things they do - well, I just don't think it's very good for them to be together. I'll really be glad when we can move and get away from here. The other children don't mind at all. They're out on the street until all hours, and now my children are beginning to think they can do the same things."

Incident 131 - After Betty told Shirley several times that she could not go to the bowling alley with the neighbor, Shirley came into the house and went into the bedroom. There was a squeaking sound from the bedroom, and Betty said, "She's gone to bed. This is another way to get me to let her go." In five minutes, Shirley went outside again.

Incident 153 - As Shirley took a malt out of the freezer, Betty said, "Everything gets frozen around here. I take them over and buy them a malt, they eat a third of it, and the rest of it goes in the freezer for three days. It's a lot more economical that way, but mine are the only kids I know that do this. They save it and save it. I can't understand it. It just seems so different." She paused, then said that Jean saved everything. "I don't know what I'm going to do about that girl. I can't understand it. She saves everything she gets. She collects and collects. Anything that anybody throws away, if she thinks it looks good, she brings it home and puts it away somewhere. Every paper she's ever made in school she's brought home and stored in there. She's got boxes full of stuff. And I can't hurt her feelings, but there just isn't room for everything. . . . She really gets upset if she knows I'm throwing anything away. She just cries and cries. I asked her one time what she saved it for and she said she didn't know, she just did and that was all. . . .Every once in a while I throw away a box that isn't important when she isn't around." (Indicated as "significant" by Dr. B.)

Incident 176 - Jean came into the front room where Betty and the nurse were talking. Betty suggested that she (Jean) go outside and play. Jean went into her mother's bedroom. There was the sound of objects being dropped one by one into an empty box. This continued for about two minutes, and then Betty said, "Jean, can't you do that more

quietly? Jean did not respond, but continued to drop the objects one at a time. Betty said, "Jean!" There was no response from Jean. Then there was the prolonged sound of a lot of small objects being poured from one container to another. Betty looked toward the bedroom, then at the nurse, and said, "That's what I like - the way they obey me. Really obedient children - that's what I've got." She changed the subject. The sound of the marbles continued. (Indicated as "new" and "significant" by Dr. B.)

Of the twenty-eight incidents assigned to this category by the psychiatrist all of them were designated as being "new" information to the patient's therapist. Of these, he rated sixteen as being "significant" and stated that others presenting the same kind of observation as these might also be considered significant but had not been marked as such. He stated that this was another area of conflict about which the patient had not talked in therapy as yet, and that this information provided another important area for exploration. He considered the incident with Leon (see below) as very significant, since the only instance in which she was able to show warmth to a child was with this three-year-old neighbor child.

Samples of the incidents which the therapist rated as "significant" were:

Incident 129 - Shirley came into the house and asked Betty if she might go with a neighbor child to the bowling alley. Betty replied, "No. It's dark." As she spoke, her voice became harsh and deep and the words were clipped. Shirley: "Please, why can't I go?" Betty: "No!" Her voice was loud. Shirley left the house. In two minutes she returned, went to the bedroom and came out wearing a jacket. She went to Betty and whispered in her ear. Betty said, "No,

these had been considered in "agreement" as to presenting this kind of information by both groups of nurse experts.

These significant incidents were descriptive of interactions between the patient and neighbors, friends or peers, and individuals in the work situation, or of comments made by the patient which related to such interactions or her feelings about them. Following the rating, two of the experts commented about some of these situations, stating that they "provided many clues" about the patients' needs for acceptance, attention, affection, approval, and social relationships, and the way in which they attempt to meet these through their relationships with others, as well as their ability to relate to others.

Among the observations which the nurse raters agreed provided information of this type were:

Incident 35 - A man walked past the switchboard to a file behind Louise. Louise said, "Hey, Bob, I want you to meet someone." He did not look at her. Louise's face flushed. "That's Bob, the fellow I've told you about. He's really funny - and fun to work with. He's always coming over and teasing me." As Bob turned and started back, Louise said, smiling, "Bob, come and meet this friend of mine." Her voice was louder and higher, her words rapid as she spoke. He came over to the switchboard and Louise said, "This is Bob S. He works in the next department. And this is Miss H." Bob's face was slightly flushed. He said, "I'm happy to meet you," then turned and walked quickly away. His face was completely serious during this time. Louise watched him walk away. She was smiling constantly. She immediately started talking again about how much fun it was to work there, especially with Bob because "he's such a character." (Underlined as "significant" by Dr. A.)

Incident 86 - At the checkout counter, Louise stopped and introduced the two nurses with her to the clerk. Louise then turned and walked quickly toward the door, with the nurses following. She introduced the nurses to two men standing near the door. As they drove away, Louise called out and waved to two men who were talking together on the sidewalk. The men were turned away from the car, but when Louise called to them, they turned and waved. During this time she was smiling brightly, face flushed, voice high-pitched and quite loud, and her words poured out. She continued to look at the men as the car pulled away and repeatedly said: "They're so nice and friendly." (Underlined as "significant" by Dr.A.)

Incident 162 - Betty said that she had been at the light company, trying to "straighten things out." They had turned off her lights because the man next door was using them too, and they said that this was illegal and unsafe." She said that she had asked the man several times for the money for the light bill, "But he just calls his wife who's expecting another baby and all of their children and lines them up in front of me and says, 'This is my wife and these are my children,' as if he didn't understand or something. And then I don't know what to do. I can't leave that poor woman and those six children without any lights. And he says that if he pays me he can't buy food for them, and then I just feel guilty for saying anything." She paused for a moment. "But then we have to eat too, and I can't afford to be feeding his family. I - well - it's really a mess." (Indicated as "new" by Dr. B.)

Incident 195 - Betty's brother was in front of the house asking a neighbor questions. His voice was teasing and the woman with whom he was talking was screaming at him. Betty said, "My brother has to come down here every day and tease Annie. Now that's a woman that's sick. She's real sick. About ten times a day she calls the police to report the children. This has been going on for years. For a while the police used to come down here, but they don't any more. She gets so angry and she threatens the children, chases them and screams at them. I try to get mine to leave her completely alone, but they can't even go near her yard without having her come out and tell them to go away. And that's a little hard when the houses are practically on top of each other."

Thirteen incidents pertaining to the patient's relationship with others (outside the family) presented "significant" and/or "new" information to the patients'

therapists. Nine of these were among the observations made of patient A. Examples of the incidents selected are:

Incident 21 - Louise showed the nurse an ironing board (aluminum adjustable) and General Electric steam-spray-dry iron which she had bought when she moved, also a cabinet for her sewing machine. "I'll have the cabinet paid for in October, and I'm trying to save $10 a month so I can take a class in night school this fall too. If I'm careful I should be able to have enough money saved by then." She continued to talk about her desire to take a psychology class at the University in the fall." (Underlined as "new" and "significant" by Dr. A.)

Incident 63 - Mrs. M., the landlady, told the nurse that Louise was upset and crying the night before and didn't want any supper. "She said her stomach was bothering her and she couldn't eat anything when she first arrived home from work." Mrs. M. thought that something had gone wrong at work and also that Louise was upset because the nurse had not been up to see her. The landlady said she had talked with Louise for a few minutes, then told her that if she felt like coming out and visiting or eating after while to do so. In about an hour, Louise had left her room and joined Mrs. M. in the front room, had eaten some salad, watched television and Mrs. M. had taught her to play Solitaire. (Underlined as "new" and "significant" by Dr. A.)

Incident 90 - Louise stated that when the nurse first came to visit her, it was very difficult to talk about anything. "Now, I feel it's easier to discuss some things with you than with the doctor because it's just kind of hard to discuss some things with a man - like sewing and cooking and a lot of things like that. I just feel kind of funny talking about stuff like that with a man, for some reason. And then I could tell you about when that dog got killed - you know, when I felt so guilty - and I couldn't ever tell anyone about that before. It's real hard for me to talk to anyone about things and sometimes I really want to. You know, just little things that happen. It seems kind of silly and yet they're important to me, too." (Underlined as "significant" by Dr. A.)

Two of these incidents are indicative of the patient's feelings about and relationship with her therapist. Doctor B.

in discussing the kinds of information which were obtained, suggested that a category should be included in which information (comments, etc.) about the patient-therapist relationship and the patient's attitude toward and feelings about therapy might be recorded. In this instance, such information was included with "patient-other relationships." It would seem to the investigator that the more limited amount of data included in this category would permit incorporation of sub-categories, such as patient-therapist, patient-peer, patient-neighbor, and patient-co-worker.

Category VII. Patient's relationship with the nurse observer.

Of the sixteen incidents which were selected by the psychiatric nurse raters as being in "agreement" for providing significant information about the "nurse-patient relationship," fourteen had also been so rated by the first group of experts. These incidents were descriptive of the patient's reaction to the visit of the nurse observer, of some verbal or nonverbal aspect of her behavior during the visit, or of interactions between the nurse and the patient.

All of the incidents included in this category by "agreement" of the psychiatric nurse experts pertained to the observations of Louise A. None of the observations of the second patient which had been selected as significant

information about this relationship by any of the original raters were agreed upon by three or more. Therefore these were not included in the second rating. Following the sorting of incidents by the first group of experts, three of them commented about the "observable difference" in the relationship with the nurse between the two patients. One stated that she "could almost follow the development of the relationship between the nurse and Louise; whereas it almost seemed like the nurse wasn't there in the other visits. It was almost as if Betty had a wall around her somehow." These raters were at least partly picking up clues from the incidents which had also seemed apparent to the investigator during her home visits. Inferences about other possible reasons for this difference in the incidents will be made later in the chapter.

The following were representative samples of the "significant" incidents which were in "agreement" for this category:

Incident 26 - Louise walked over to the overstuffed chair away from any other furniture on which the nurse could sit and sat down. Her face was flushed and her voice was high-pitched and words were rapid as she talked.

Incident 27 - Louise stood immediately when the nurse said she was leaving. Nodded when the nurse mentioned she would be back. Walked the nurse to the door, then turned and went into the bedroom before the nurse left.

Incident 32 - The nurse asked Louise if she planned to be home the following Tuesday evening. She replied,

"Well, yes, I guess so, but wouldn't it be better if - well - isn't it easier for you if you just come on the weekends?" Nurse: "Is it easier for you if I just come on the weekends?" Louise paused for about 30 seconds, then said, "Well, yes, I can get more things done and it is a little bit better for me." The nurse then asked if she (Louise) would be home on Saturday. She replied that she didn't know whether she was going into town or not. The nurse said she would call later to make an appointment to see her. She hesitated, then said, "Well, you know I don't get home until 7:00." Her words were quite rushed and she looked straight ahead and opened and closed her hands constantly. The nurse said she would call her after 7:00 P.M. Then Louise said, "Well, all right," pausing between her words. The nurse opened the door to leave and Louise said, "Thank you."

Incident 39 - Louise hurried out of the front door and almost ran down the walk toward the nurse. When she saw her car, she called out, "Let's go for a ride." Her face was flushed, eyes bright, body rigid. The nurse responded, "All right." Louise did not look at her father who was working on the lawn as she went past him. He made a comment to her, but she did not respond. As soon as the car doors were closed, she said, "I think you're going to be mad at me. I'm moving into the house where you live. I didn't know you lived there when I went to look at the room, or when I said I'd move in. I'm not just moving there because you live there. I can't rent the other apartment, but the landlady there told me about Mrs. M.'s house and I went over to see it. When I got home I was going to call you to tell you that I'd found a place and then I found out you live there too. Are you mad at me?" She looked straight ahead as she talked and her face was very flushed. Her voice was high-pitched and words poured out rapidly. Several times she asked the nurse if she was "mad" about this move. ("Significant - and some new information, too." - Dr. A.)

Incident 55 - Louise's hair was uncombed. She was wearing a long (almost to her ankles) unpressed dress with no belt, house slippers, and no makeup when the nurse arrived. While ironing brother's shirt, said, "You didn't say you were coming today. Why didn't you tell me? I don't like it when you don't let me know. I just look terrible." When the nurse attempted reassurance, Louise said, "Yes, but your hair is combed and you look all right. How would you like me to visit you if you were like this?" (Underlined as "significant" by Dr. A.)

In regard to the fifteen incidents selected by the doctors as relating to the "nurse-patient" relationship, the psychiatrist rated four of them as providing "new" information. Nine were considered to be significant to them in relation to therapy and two others were marked as both "new" and "significant." In regard to this information as it related to the patient A., the doctor stated that a marked improvement had occurred in her illness since the visits to her home were begun (although she was still very ill), and that he attributed this to the "change in her environment created by these visits." These incidents were indicative of the changes in the relationship which may have provided the impetus needed by the patient to move from a "sick" family environment.

Only two of the above mentioned incidents were among those selected by the psychiatrist as having particular meaning for him. There were six others among those selected by the nurse experts as "significant" and in "agreement" for this kind of information which were not among those selected by the doctor. Seven incidents were rated as "new" and/or "significant" and pertaining to this kind of information by the psychiatrists which were not among the nurse experts' group. The majority of these incidents were found to lack agreement during the first sorting by the experts. Two,

however, were rated as "not significant" by this group. These two incidents are shown below.

Incident 40 - The nurse and Louise had been riding in the car and talking throughout this visit. When they arrived at the patient's home, she sat in the car talking for about ten minutes longer, then said, "Well, I'd better go in and let you go." She got out of the car, turned and walked up the path toward the house. She entered the house without looking back. (Underlined as "significant" by Dr.A.)

Incident 181 - Betty was waiting on a customer when the nurse and an observer entered. At 2:00 the nurse asked Betty if she would like to get a cup of coffee and join them at one of the tables. She looked at the clock, immediately took off her apron, obtained a cup and saucer, filled the cup with coffee and walked with the nurses over to the table. She sat with them and chatted about work and her fellow employees, answered questions and made comments in response to the remarks of the nurses. When she had finished her coffee, the nurse asked if she would like a ride. Betty quickly said, Why, yes, I'd like to go over to Grand Central if you don't mind. I can look around over there until it's time to go to the doctor." (Indicated as "significant" by Dr. B.)

The investigator felt there might be three reasons for the differences between the two disciplines in the above-mentioned ratings. One was that the nurse experts may have been looking for clues as to the development and stages of the nurse-patient relationship, and the incidents selected by them in this category seemed to be indicative of these two factors. A second factor might be indicated by the selection by the doctor of specific comments which he felt provided the "significant" information, based on his knowledge of the patient and her illness. (This is seen in Incident 40.) The third factor is closely related, in that it

relates to the doctor's awareness of the patient's inability to relate to others, and therefore he would be able to pick out items which were indicative of a change in her pattern of relating (such as was indicated by Incident 181).

Category VIII. Family members' attitudes toward self and others, and relationship among selves and with others (excluding the patient).

Five incidents were rated as providing significant information and being in "agreement" for this category by the psychiatric and mental health nursing experts. Three of these had also been agreed upon as providing significant information about "family members' attitudes and relationships" during the initial rating of the data. The incidents included described: interactions between the patient's parents and the parents with the nurse, comments by the parents relating to neighbors and others, and a statement by the patient regarding the relationship of her parents to each other. One of the experts rating the incidents commented that those she had marked as providing significant information about the family members' attitudes and relationships had seemed quite indicative of the parents' value system, and of the basis for some of the problems which the patients might be having.

The following are samples of these incidents:

Incident 70 - Mrs. A. was in the kitchen. Louise

and the nurse were talking in the front room. Suddenly the back screen opened, Mr. A. ran in calling out, "Fire!" The screen door slammed and he again yelled "Fire!" He glanced in the front room at the nurse, hurried over and closed the kitchen door. There was the sound of scurrying footsteps in the kitchen, and Mr. A. said, "For hell's sake, woman, get some water. Hurry it up. Don't be so damned slow. There's a fire out there." There was the sound of water running into a bucket, and Mr. A. again said, "Hurry - it's on fire out there." The water was turned off and there was the sound of hurrying footsteps in the kitchen and the screen door closed, more softly this time. Mr. and Mrs. A. did not return to the house again while the nurse was there. (Rated as both "new" and "very significant" by Dr. A.)

Incident 101 - Mrs. A. had brought some rhubarb into the front room for the nurse. She then walked over to the sewing machine, turned to the nurse and said, "Do you know about Civil Defense?" The nurse said, "About Civil Defense?" Mrs. A.: "Yes, what they're talking about and you're supposed to do and everything?" Nurse; "Just a little. Are you interested in Civil Defense?" Mrs. A.: "Oh, they asked me to take this block - go and see all the people and give them things and everything. And - well, it seems like a person's so busy all the time. It's just too much. But my neighbor is in charge of this area and-and she asked me to do it and so I said I'd try."

Incident 209 - Mr. D. was seated on the end of the couch, smoking a cigarette and looking straight ahead. The television was on and a negro woman came onto the screen. Mr. D. said, "If there's anything I can't stand, it's Mexicans and Negroes. And it seems like they're everywhere I go now." "There didn't used to be any around here, but now they're all over the place. Negroes living down on the corner-just all over." He was silent as Betty came into the room. (Rated "new" and "significant" by Dr. B.)

A total of eleven incidents were marked by the therapists as "new" and/or "significant" information about the family members as they related to understanding of the patient's illness and planning patient care. One of these (Number 70 above) was among several felt to be extremely

important by Doctor A. In commenting about these incidents, he said that "the most important new information you provide is the description of Louise's Father. I have always assumed that Louise's Mother is schizophrenic - now you provide evidence that Louise's Father is also schizophrenic - her reference to him in therapy has been nil."[1]

Both doctors indicated that the kind of information provided about the parents had significance in relation to the dynamics of the patient's illness.

As was previously mentioned, Dr. B. stated that he had not been aware of the father's existence before this time. He also felt that the observations of the parents' interactions provided significant clues to the patient's present attitude, conflicts and problems. A sample of the incidents which were considered significant by this doctor is:

Incident 212 - Betty's parents were in the backyard and Betty said to the nurse, "I don't know why or how they've lived together all this time. I really don't. They don't like each other. They just - well - Friday night he starts drinking and he really goes strong until Saturday night. He won't touch a drop all week, but every Friday night -" There was a slight pause. "And Mother doesn't say a word on Saturday. She doesn't dare. She knows it's the only time he'll tell her - he's brave enough then to do it and he doesn't care what he says. But that's the only time he will.

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[1]Personal communication by the doctor relating to his rating of the incidents.

Then she starts real early Sunday morning - she wakes him up on Sunday morning so that she can get an early start, and he really has a bad day. She won't let him forget it. And she goes back 20 years and brings it up to date. Twenty years! Once I asked him about it - what happened 20 years ago, but he just shrugged and said that it didn't matter now. She'd harped on it so long and wouldn't try to understand and he didn't want to talk about it." There was another pause. "But she always takes him back 20 years and then rehashes everything since then." (Rated as "new" and "significant" by Dr. B.)

Two other illustrations of the incidents considered to be "significant" by the doctors were:

Incident 67 - Mrs. A. was telling the nurse about helping with the Civilian Defense program and said, "I - well - I've got to go and visit all the people in this block and take them things and find out if they have anything ready. I didn't want to - it's kind of hard. I mean there's no time and so much to do, but my neighbor asked me and she's doing the whole program and - and she thought I could do it. She really talked me into it. And because she asked me, I told her I'd really try."

Incident 207 - Mr. D., Betty's father, commented that he was "under the weather," that he was sick with the flu or something and had been trying to "drown it," but that this really hadn't helped. "When I'm sick, I can't tell whether I've been drinking anything or not." His face was flushed, his voice husky, and he had a deep cough. He said he had had pneumonia a few months before and was afraid of getting it again. "I thought a little alcohol would make me feel better, but I think I only really feel worse."

Both of these incidents lacked agreement as to the kind of information they presented when they were first grouped by the psychiatric and mental health nurses. The "significance" of each was also questionable as they were considered not significant by two of the five raters. The differences in these ratings, as well as the number of

incidents included in this category of information, might be due to the lack of background information sent to the raters about the patient and family, or a difference in perception by the various individuals as to the kind of information that is significant. It was noted by the investigator that only three of the original nurse raters included a grouping which related to other family members but not to the patient. Two of these three had had public health-mental health background, and one inference made by the investigator was that because the importance of the "family as a whole" is stressed constantly in public health nursing, information about family members might be perceived in a different way and as more significant to these particular experts. With the emphasis placed on "patient care" by psychiatric nursing, the incidents rated as "significant" about other family members may have been categorized in various ways as they were perceived to be important to the patient or to the nurse in planning patient care.

Category IX. Patient's work adjustment and performance.

Only one incident was found to be both "significant" and in "agreement" for poviding information about the patient in relation to work performance and/or work adjustment. This incident was rated in this category by only two of the three experts at the time of the second rating

and had not been in "agreement" as to providing this kind of information on the former rating. (As was previously mentioned, although observations had been made while each patient was at work and several incidents taken from these observations had been included in the study and were marked as significant by four or five raters, none of these were in "agreement" for providing information about work adjustment or performance on the initial rating. Several were identified as such by two of the five raters, but were deleted because of lack of "agreement" for presenting any one kind of information.)

The one incident which was included in this category on the final rating is:

Incident 1^{44} - Betty said she had become "very upset" at work. She had forgotten something for one customer and had to be asked for it, and had taken another customer two bowls of soup (one after the other) and two salads, forgetting that she had taken the first one. The customer had told her about it and she said she became very angry at him and kept insisting that this hadn't happened. "But I know he must have been right. It upset me a lot. Usually I don't have any trouble at all. It really frightened me when I realized I'd forgotten so easily. It was so hard for me to think about work and what I was doing. It's all just sort of automatic, and I really am not sure what I should be doing part of the time - or it seems like I'm not. It frightens me that I might be getting mentally sick again."

Four incidents were rated as presenting "new" and/or "significant" information about the patient in relation to her work by the psychiatrist. Incident 1^{44}, quoted above, was one of these four. A second illustration is presented

below:

Incident 102 - In commenting about work, Louise said that Pat, one of the other employees, was afraid she was going to be fired. There was a long pause, then she added that if Jane (a supervisor) "got it in for you, then you were sunk. And she had done this before - with the last switchboard operator. Of course, everyone tells me I'm doing a really good job, especially since I haven't been there very long. And Jane really seems to like me, so I guess it'll be O.K." (Underlined as "significant" by Dr. A.)

The descriptions of the patient's work performance (Incidents 25 and 172) were rated as being of questionable significance to the psychiatric and mental health nurse experts. The doctors also rated these as being not significant, although the description of Betty's work (Number 172) was marked as providing "new" information for Doctor B. At this time, the investigator questions the significance of this kind of information. Since employment for a woman often has different meaning than it does for a man, an area of further investigation may be indicated to determine if work performance adjustment descriptions of men are more significant in terms of therapy than those of women. (On the basis of her own observations, the investigator felt that these particular descriptions were more indicative of the patient's ability and need to maintain control of her feelings when she was around others than to provide insight into strengths, dynamics of behavior, etc.)

Category X. Patient's Interests and Hobbies.

Although four incidents were designated in this category by one of the three raters, there were no incidents rated by the nurse experts as being "significant" and in "agreement" for providing information about the patient's interests and hobbies. Whether the basis for this was that: (1) this kind of information is not perceived as being significant to the psychiatric nurse, (2) the investigator did not obtain this kind of information during her observations, (3) the incidents which might have provided this kind of information were deleted following the first rating because of lack of agreement, or (4) the incidents pertaining to patient interests and hobbies were such that they provided more than one kind of information and were perceived as being more significantly related to other categories, was not determined. Therefore, further study would be needed in order to substantiate or refute the inclusion of this category of information among those determined by the study as being significant and obtained by observation of the patient in the home.

One incident (Number 192) was felt by the investigator to provide this kind of information - and to indicate an area of interests from which motivation of the patient to more constructive thoughts, ideas and activities might begin.

Incident 192 - Edith commented that Betty had made the girls' dresses for their First Communion and had really put a "lot of time and fuss" into them. Betty smiled, leaned forward and said she had enjoyed preparing the girls. "I had difficulty with the collar of one and had put it on about ten times before I realized I would have to cut it a little bit differently to fit the dress." As she talked about making the dresses and veils, her voice became a little bit higher, her words a little more rapid, she moved her body forward and her eyes and lips were smiling. She said she had really enjoyed making the outfits - "At that time I really enjoyed sewing."

All of the psychiatric and mental health nurse experts, as well as the psychiatrist, rated this incident as presenting "significant" information. However, there was no agreement between any two of the nurses as to the kind of information it provided on the first sorting. (As a matter of interest, the investigator included this incident in the second rating, and again there was no agreement as to category between two of the raters. This would indicate to the observer that the incident either presents several kinds of information or was written in such a manner that the description was not clear and it might therefore be more apt to be perceived in a variety of ways.)

Category XI. Patient's and family's reaction to stress and "crisis" in the home.

Of fourteen significant incidents rated by one or more of the three psychiatric nurse experts as providing information about the patient's and family's reaction to stress and "crisis" in the home, only one was found to be in "agreement"

for this category. Six of the remaining incidents lacked agreement for any category of information, and the other seven fell into categories on the basis of being so classified by two of the experts.

The incident included in this category is:

Incident 204 - Betty stated, "When Mother learned that I was going to have to move in with her, she went to Las Vegas suddenly for a couple of days. She just couldn't take to the idea. She'd been ignoring the problem until the last minute, and then she just had to leave." Betty had tears in her eyes as she said this. (Indicated as "significant" and "new" by Dr. B.)

This particular incident was also rated as providing both "new" and "significant" information to the physician, as he felt the parent's reaction to Betty's decision to move in with her, as well as her feelings about this reaction, were indicative of the conflict between them and provided an additional basis for understanding the dynamics of the patient's illness.

Five additional incidents were rated as either presenting "new" or "significant" information which might be considered dynamically as they relate to the patient's illness. Following are examples of these incidents:

Incident 61 - Louise cleared her throat, there was a pause of about 30 seconds, then she described an incident which had occurred at work which "upset me a lot." Mr. L. (the boss) had asked her to tell his wife, if she called, that he wasn't in. She did call, and when Louise said he wasn't in, she asked to speak to her son and then to Mr. L's secretary. After talking with them both, then Mrs. L. called

Louise back and "bawled me out for about five minutes because I had lied to her." As Louise described this incident, tears came into her eyes, she kept continually clenching and unclenching her hands and her voice would rise then drop in volume, but remained constantly at a high pitch. She had started to cry when Mrs. L. hung up. "Jane (the secretary) came over and took the switchboard so that I could have a few minutes to get feeling better." There was a pause of about a minute. "Everyone tells me not to pay any attention to her (Mrs. L.) - that she's really hard to get along with and even Mr. L. doesn't pay any attention to her any more." Then she changed the subject.

Incident 182 - Betty's eyes were red and swollen and there were dark circles under them. She said that she had just been notified that she would have to move in six days. She stated that she was angry because she had been told it would not be necessary for her to move until school was out. Suddenly a man had come and said they were going to turn off the lights and water on Sunday because they planned to tear the building down to make way for the new highway as soon as possible. Throughout the visit there were tears in Betty's eyes, her voice was low and her speech blocking. She sat silently for long periods of time. Several times she commented about being "very cold" and unable to get warm, saying that she felt "cold inside, all the way through."

The limited number of incidents rated in "agreement" as providing significant information about reaction to stress and "crisis" leaves serious doubts in the mind of the investigator as to the feasibility of considering this in a separate category. Certain similarities between this and Category III (patient's conflicts, needs and problems) might provide one answer for the few incidents rated in this area. Also, reactions to stress are frequently seen in interactions with others, and the data may have been felt to be more significant in terms of relationships than behavioral reactions.

Again, the perception of the individual raters, as well as the ways in which the incidents were grouped at the time of the first rating and categorized by the investigator, influenced the number of items retained which might have provided this kind of information. Further study would be needed to positively state if such information is obtained by observation in the home, and the significance of this information to dynamics and therapy in relation to the patient.

Category XII. Patient's and family members' attitudes toward and relationship to pets and inanimate objects.

Three significant incidents were rated by the psychiatric nurse experts as being in "agreement" for presenting information about attitudes and relations of patient and family members to pets and inanimate objects (out of five incidents placed in this category by one or more raters). These three incidents were:

Incident 150 - Jimmy came into the house, leading a large black dog. Betty said, "Oh, he's brought Blackie home with him again. This is all we need, another dog. You know how many pups our dog had? Our dog I call it, only it's not ours. I don't know what we're going to do with the thing. Seven pups! Now we've got eight dogs and Jimmy brings Blackie home." "Blackie was given to the children, but we only had him a few days, then we gave him to Mother." Each time she spoke of the dogs her eyes became very serious, and at one time tears formed on the lower lids. She sometimes smiled with her lips at the same time. "I've tried to give the pups away, but I can't do that. I'd like to lose them. I've just got to call the Humane Society tomorrow to come and get them. The children will just die when I do, but I've got to get rid of them."

Incident 210 - Mrs. D., Betty's mother, was seated on the end of the davenport and one of the dogs went over to her and jumped up on her lap. She hugged and petted the dog for several minutes, commenting that this dog was very lovable, liked a lot of attention and couldn't stand to be punished. "Every time I punish her, she has to make up. She really gets her feelings hurt until I hug her and let her know it's all right."

Incident 211 - Betty commented, "My Mother is able to give the dogs a lot more affection than she could any of us. And with the children - she can give affection to Jimmy but not to the girls. I really notice that. And she did it with my brothers too. But I think she even does it more with the dogs. They're even more than like children to her."

All three of these incidents were classed as "new" information by the psychiatrist and Incidents 210 and 211 were also considered to be "significant." In discussing the observations about the patient's and family's relations to pets, Doctor B. said that the interactions seemed to indicate some similarity of behavior of the patient to that of her mother, as well as being indicative of the patient's ambivalence toward the animals.

An additional three incidents selected from the observations of patient A. were rated as presenting "significant" information about this patient, the dynamics of her behavior in relating to her pet and also some progress in therapy. Two of these incidents are presented here.

Incident 18 - As the nurse parked her car in front of the house, Louise came out through the front door and glanced at the car. Her face was flushed. She walked around the side of the house and disappeared from view. Louise entered the house through the back door. Her face was flushed,

looked at the nurse and then down. Nurse introduced herself. Louise nodded, said Dr. A. had mentioned the nurse's visits. Speaking rapidly, Louise said, "Don't you want to come out and see my dog?" The nurse agreed that she would like to and went out through the back door with Louise. (Underlined as "significant" by Dr. A.)

Incident 46 - A blond cocker spaniel puppy was tied by a rope to a board in the barn behind the house. Frolicked to Louise and jumped on her two or three times. Louise patted the puppy, picked it up and squeezed it, then put it down again. She commented that the pup was about five weeks old, and that she had had it for only a short time. She then turned and walked out of the barn toward the house without any other comment. The nurse followed behind her. (Underlined as "new" and "significant" by Dr. A.)

None of the incidents selected for this category pertained to inanimate objects, although two of the experts mentioned that some of the observations did give this kind of information. However, they felt that other information in the incidents was more significant and they had placed them in another category. (The significance of this to the study will be included with the limitations.) The content of the incidents included in this category as "significant" and "meaningful," and the comments of the experts would suggest that incidents providing information about the patient's and family's attitudes and relations to inanimate objects was not observable in these situations during the visits by the investigator, included in the selected incidents, considered significant by the experts (or as significant as other kinds of information), or was deleted from the study

TABLE I

NUMBERS OF THE INCIDENTS BY CATEGORY TO WHICH THEY WERE ASSIGNED BY THE PSYCHIATRIC NURSING EXPERTS

Number of Incidents	Number of Incidents by Category											
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
1	1	8	6	10	118	35	18	53	144		204	150
2	2	12	7	11	119	86	26	70				210
3	3	36	17	13	123	99	27	101			211	
4	4	41	68	14	124	125	28	209				
5	5	56	69	15	127	138	29	212				
6	100	89	74	16	130	162	31					
7	108	106	104	47	131	185	32					
8	109	114	107	50	132	189	34					
9	122	134	112	51	133	195	39					
10	196	141	113	52	136		42					
11	201	183	128	59	137		43					
12	203	190	135	91	140		55					
13		191	151	115	143		77					
14		193	157	155	145		87					
15			167	177	146		90					
16			174	202	147		95					
17			186		152							
18			188		153							
19			194		154							
20			199		156							
21					158							
22					159							
23					176							
24					178							
25					198							

TABLE II

NUMBERS OF THE INCIDENTS BY CATEGORY TO WHICH THEY WERE ASSIGNED BY THE PSYCHIATRISTS

Number of Incidents	Numbers of the Incidents by Category										
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI
1	1*	6*	7'*	10*	117'*	21'*	28*	53*	102*	61*	1
2	2*	8*	35*	11'*	118'*	24'*	29*	67*	144'	105*	4
3	4'*	12*	50*	13'*	119'	37*	33*	68*	172'	148'	4
4	108'	20'*	69*	15'*	120'*	44'*	34*	70'**	173'	182'*	15
5	122'	22*	86*	16**	123'*	63'**	39'*	83*		183'	21
6	165'	23*	88*	17*	129'*	84*	40*	100*		204'*	21
7	200'	36*	92*	49'*	130'*	90**	41'	110'			
8	201'	45*	93'*	51*	131'	94'	42*	155'			
9		57*	104*	52*	132'*	97*	43*	207'*			
10		85*	107*	54'**	133'	125'	55*	209'*			
11		89'*	111*	71'**	136'*	162'	56*	212'*			
12		90**	113'	72*	139'	169*	87'*				
13		98*	127'	73'*	140'*	189'	126'				
14		103*	134'	74'**	143'*		175'				
15		106*	138'	91*	145'		181'				
16		121*	141'*	177'*	152'*						
17		128'*	157'	180'*	153'						
18			160'	202'*	154'*						
19			163'*	205'	156'*						
20			166'*	206'*	158'						
21			174'*	208'*	159'						
22			184'		164'						
23			185'		167'*						
24			186'*		170'						
25			188'		176'*						
26			191'		178'						
27			193'*		191'*						
28			194'		198'						
29			199'*								

* - Rated as "significant"
' - Rated as "new"
** - Rated as "very significant"

because of lack of agreement during the first rating. Before concluding that such information is not significant to the psychiatric nurse or psychiatrist or is not available by the observation in the home, further study would need to be made.

"No Agreement" - First Rating:

There was a variation among the types of incidents which were not in "agreement" as to similarity of groupings on the first rating by the psychiatric and mental health nurse experts. Twenty-one of these were rated as "significant" by only three of the judges, and therefore the significance of these incidents for providing any kind of information is questionable. However, one of these was marked as "significant" information by the psychiatrist in relation to the patient's progress in therapy. The incident so classified was:

Incident 98 - Louise sewed all during the nurse's visit, hemming a cotton dress. She commented that the dress was "just to wear around the house." When the nurse said it was really "cute" and she might enjoy wearing it to work, Louise said, "Oh, it's such cheap material I don't like this kind of a dress for work. I just like to wear it around the house." She said that she likes to embroider and knows how to knit "a little, but not as well as my sister." "I make quite a few of my own clothes, especially since I learned to put in zippers. I learned how once in the 8th grade, but it was always so hard and I always had the feeling that I wouldn't be able to remember the steps and everything. So I always had a feeling I wouldn't be able to make a dress with a zipper in it, but now they have directions on the zipper package and it's just real easy." (Underlined by Dr. A.)

Among the other incidents which were of questionable significance to the psychiatric and mental health nurses, the investigator had described: brief interactions between the patient and her children, or with fellow employees at work; the patient's work performance; the patient's sewing and her comments about this activity; comments by the patient about her work and her family; and interactions between family members and the nurse. Illustrative of other incidents which were rated questionable in significance and as not being in "agreement" by these experts for providing any one kind of information were:

Incident 205 - Betty said, "I'm going to baby sit tonight with my sister's children. They go over to church to play Bingo. That's their way of donating." She laughed and said, "And Mother goes with them. She just loves that game. She wouldn't miss Bingo on Saturday night for anything." Later in the visit Betty commented that her parents go to Las Vegas once a month, sometimes to Elko and sometimes to Ely. "Mother just loves that trip. I think my father just gets stinko, but Mother loves the trip and to play at the tables a little."

Incident 83 - Mr. A., a small man wearing overalls and a work shirt, was in the orchard beside the house pruning the trees when the nurse arrived. He looked at the nurse, smiled and said, "Hello," as she approached. He commented, "There's so much work to do all the time." He then walked away from the nurse to some trees which were further away.

Incident 173 - At about five minutes of two, Betty glanced at the clock and kept looking at it as she moved about the cafe. At 2:00 P.M. she removed her apron, picked up her purse and cigarettes and started toward the door without speaking to anyone. She left the cafe. Soon the cook ran out and called, "Betty." She turned back and said, "What do you want?" He told her he just wondered if she was

leaving, and she said, "Yes. It's 2:00 and I always leave at two." He nodded, and she turned and walked away.

There were four incidents which were marked as "significant" by four or more of the original group of raters but on which there was absolutely no agreement as to the kind of information they provided. As was previously mentioned, one of these incidents (Number 192) was included in the second rating by the investigator to determine if this scatter would be repeated a second time - and it was. This incident was rated as "significant" by all of the experts; but the categorization was scattered so that on the first rating it was placed in each of the following Categories: II, III, V, VI, and X. The second group of experts showed some similarity in scatter of placement as the incident was again rated as providing significant information in Categories V, VI, and X.

The remaining items which were marked as "significant" by the psychiatric and mental health nurses, but which were not in "agreement" as to the grouping in which they were placed, were descriptive of: interactions between the patient and siblings, the patient and others (outside the family), and the patient and the nurse; the patient's use of or problems with finances; the patient's comments as to feelings about herself in relation to work, to religion, to peers, to her mother, to her fears and guilt feelings, and to her conflict about her "illicit" sexual relationship with a

married man; attitudes and reactions toward the neighbors; interactions between other family members and the nurse (or the patient, family member and the nurse); and comments of the patient regarding things she has enjoyed or might in the future enjoy doing.

Seventeen of these incidents had been rated as "significant" by four of the first group of experts, and twenty-eight were considered significant by all five experts who completed the rating. As a matter of interest, the investigator included these incidents ("significant" but not in "agreement") in the second rating in an attempt to see if the specified categories would provide a framework within which more "agreement" might be found. On this rating, sixteen of the forty-five incidents were placed in the same categories by all three of the experts. Following are examples of these incidents and the category in which they were placed during this second rating:

Incident 45 - Louise was talking about playing softball and said that Lucy (the team manager) and her friend planned to pick her up after work and take her to practice. Then she added, "I told them about me - about my trouble in high school and going to the doctor - and-they acted kind of funny. Like - well - I don't know, but maybe they won't want me to play with them now." (Category II) (Underlined as "significant" by Dr. A.)

Incident 47 - The nurse asked Louise about her puppy. She shrugged her shoulders and said, "Oh, he's out in the back tied up." She paused, then smiled and looked up. "I have to keep her tied up unless I'm playing with her. She's

really cute." The smile left her face and she said, "Out here near the highway we have to be careful. We had two dogs get killed. It was - awful." Her voice had become low and rather hesitant. "I don't want it to happen to her. I don't have much time to play with her now that I'm working, but I like to be with it as much as I can. She's so soft and cute - and she runs and jumps on me and everything." She was smiling again as she said this. (Category XII) (Underlined as "new" and "significant" by Dr. A.)

Incident 57 - The patient's brother, Stan, was in the front room. Louise was ironing some shirts for him. Stan smiled as soon as he saw the nurse, commenting to Louise that he had met the nurse at Church in the city. Louise did not answer, but nodded her head slightly. Her face was flushed and she continued to look at the ironing board. Stan stuttered and each time he spoke, the patient's body tensed and her head dropped slightly. She finished ironing the shirt, handed it to Stan, turned and went into the bedroom. She returned to the front room after Stan left, then asked the nurse how well she knew him and if he had told her about herself. Louise changed the subject after the nurse said he had not discussed her. (Category IV) (Underlined as "new" and "significant" by Dr. A.)

Incident 78 - Mrs. A. answered the door after the nurse had knocked twice and had waited about four minutes. She said, "Hello," opened the screen door and said, "Come in." She said Louise was out in back with the dog and would be right in, then turned and left the room (going through the kitchen and out the back door.) The nurse was left standing by the front door. (Category VIII)

Incident 97 - Louise showed the nurse a drawing she had done of a kitten slipping off a stack of books. She said this was one of her best drawings and that she had made it in high school. The kitten looked realistic and Louise's teacher told her it was "very good." She then asked the nurse if she had seen the picture of the horses which she had drawn for Dr. F. Louise suggested, "Why don't you ask him to let you see them? He thought they were pretty good." Category X) (Doctor A.'s comment: "I thought they were excellent and told her so.")

Incident 111 - Betty had just told the nurse about her feelings of guilt and confusion about her relationship with J., a married man, and she said, "I went to Confession -

I thought it would - might help -." There was a long pause, then, "But - there was - Father just told me to stop and - (slight pause) - there was nothing except more -- I didn't even do the Penance. And I can't go back It's the first time I've been for months and I hoped but -." There was a long pause and then she changed the subject. (Category III) (Indicated as "significant" by Dr. B.)

Among these just-mentioned incidents, five were rated as "new" and/or "significant" to the physician. That portion of the incident which presented the important data to the therapist was underlined and the category representing the kind of information it conveyed was indicated with each incident.

Another nineteen of the significant incidents which were not in agreement as to category during the first rating were categorized in the same way by two of the three nurse experts during the second rating of the incidents. Below are samples of these incidents:

Incident 23 - Louise was sitting at the switchboard at work. She looked up at the nurse and said,"This job is really fun sometimes, but - well, when it's like this - it's been so slow this afternoon and there wasn't much to do, and the time really drags. Sam S. gave me some dictation over the switchboard yesterday and that was really kind of fun. I don't usually have a chance to do much of that. Jane always does it." She paused and looked up at the radio system over which music was being played throughout the store, then said, "If it wasn't for the music, sometimes I'd just go crazy." (Categories IX and XI) (Underlined as "significant" by Dr. A.)

Incident 197 - Betty looked at Annie's house. "There really are some sick people down here. There's a man across the street who goes over to the school and exposes himself to the children. He's been reported to the

police and they're just trying to catch him doing it. They say they can't do anything unless they catch him. And then the man next door - I feel so sorry for that family. Those children - some of them are grown and married and seem to be doing all right. But one of his daughters was pregnant when she was only 11 - and they think he's the father. And he's drunk all of the time. When he works, he spends all of his money for liquor. His wife finally left, but some of the children stayed with him for a while, and that was really a mess. And Tom - they live next to Annie, you know - he's got three cafes now and he goes at 4:00 A.M. and doesn't get home until 11:00 P.M. He's just going to kill himself and the children never see him. They have six children, but they don't even hardly know they have a father. It seems so strange that he'd be away so much when the children really need him so." (Categories I and VI)

Nine of the incidents which were included in the second rating although not in agreement as to category on the first, were still found to have no agreement. Two examples of these incidents are:

Incident 48 - Louise said, looking down, "I really don't do much around the house to help. Mother doesn't think I do anything at all, and I guess I really don't. I don't really mind doing housework, except the dishes and I don't like to do those at all. I really hate to do the dishes." Several times she repeated that she really disliked doing dishes and very seldom did them. "Anything to do with the dishes, even, I don't like to do. I even hate to set the table." There was a long pause during which Marie continued to sew. (Categories III, IV, and IX)

Incident 148 - Betty was talking about work and said, "Sometimes I get so tired and sometimes I feel like I just have to leave - can't stay there any longer. But somehow I do. It's so hard, but - well, it's about the only thing I can do with those hours and everything. And I feel that it's so important to be home with the children - to be there when they are. And it's really the only kind of work I can do." There was a long pause and then she changed the subject. (Categories II, IX and XI)

The differences in "agreement" between the two ratings

might indicate that: the categories as they were defined by the investigator were quite different than the groupings of significant incidents as they were selected by the first group of experts; the incidents present more than one kind of information; certain kinds of information may be more important to one person than another; perceptions of what is seen, heard, or read vary between individuals even when their backgrounds are similar; or that having a framework on which to "hang" the incident provides a common ground for understanding and interpreting the data. On the basis of what has occurred in the ratings of incidents in this study, hypotheses which would provide insight into bases of these differences might be developed and studied.

No Agreement - Second Rating:

Of the twelve significant incidents which fell into this category ("agreement" on the first, but not the second rating), three had been selected for the designated category by only three of the experts in the first rating and were therefore considered to be of questionable "agreement" on that rating. An example of the incidents on which agreement was not questionable on the first sorting by the raters, but on which there was no agreement when categorized the second time, is presented below:

Incident 54 - Louise and the nurse were sitting in

the front room, talking. The back screen door opened suddenly and Mr. A. ran in, calling out, "Fire!" Louise smiled slightly and continued talking. Mr. A. started to swear and the patient's face became flushed and she looked down at the floor. Her voice became higher and her words faster. There was the sound of running water in the kitchen and Mr.A. told Mrs. A. to "Hurry - it's on fire out there!" The nurse glanced toward the kitchen. Louise looked up at her, smiled and said, "Oh, that happens all the time when he's here. He's always setting the place on fire. I don't pay any attention any more." And she continued to talk about work, sewing, etc. When Mr. A. left the house, the patient's body relaxed. (Underlined as "new"and "very significant" by Dr.A.)

This incident was placed in Category V by all the experts during the initial grouping and in Categories III, IV, and XI when the experts were provided with the categories into which it might be placed. (Table I provides the numbers of all the incidents which were rated in a somewhat similar manner.) This particular incident in its entirety was considered by Dr. A. to be both very "new" and very "significant" in terms of the patient, her relationship to her father, and her illness.

Not significant:

Most of the incidents rated as "not significant" by the first panel of psychiatric and mental health nurse experts were commented upon by one of the raters as being somewhat "sterile" and without sufficient background information or detail to have much meaning. Another rater commented that all of the incidents had "some significance" but that "these seemed to be less meaningful to her in terms of understanding

TABLE III

INCIDENTS DELETED BECAUSE OF LACK OF "SIGNIFICANCE" OR "AGREEMENT"

	Incidents "Not Significant" and With "No Agreement"					
Number of Incidents	Not Significant			No Agreement by Nursing Experts		
	Nurses	Psychiatrists		Rating 1		Rating 2
1	30	3	115	19	93	9
2	38	5	116	20	94	54
3	40	9	124	21	97	71
4	46	14	135	22	98	72
5	96	19	137	23	102	73
6	139	25	142	24	103	105
7	161	26	146	25	110	121
8	181	27	147	33	111	142
9	187	30	149	37	116	149
10		31	151	44	117	166
11		32	161	45	120	168
12		38	168	47	126	182
13		48	171	48	127	
14		58	187	57	148	
15		59	190	58	160	
16		60	195	60	163	
17		62	196	61	164	
18		64	197	62	165	
19		65	203	63	169	
20		66		64	170	
21		75		65	171	
22		76		66	172	
23		77		67	173	
24		78		75	175	
25		79		76	180	
26		80		78	184	
27		81		79	192	
28		82		80	195	
29		95		81	197	
30		96		82	200	
31		99		83	205	
32		101		84	206	
33		109		85	207	
34		112		88	208	
35		114		92		

the patient or family, or planning patient care." The incidents so rated were usually brief and were descriptive of interactions between the patient and her children, her brother, her puppy, and the nurse. One (Number 96) described the patient's television viewing interests and her conversation about current local and national news.

An example of the incidents which were considered "not significant" follows:

> Incident 161 - Betty showed the clothes she had purchased for the children for Easter. Each of the girls had a nylon dress, a full half-slip, new shoes and flowered headpieces. She had bought Jimmy slacks and a jacket, a "dress" shirt, a bow tie, and shoes. Jimmy had not been with her when she bought the clothes and she said, "Oh, I hope they're the right size. I just couldn't remember for sure what size to get." Jimmy came in tried them on and they did fit.

Five of the fifty-four incidents which were rated by the doctors as not being "significant" and/or providing "new" information were in agreement with the ratings of the nurse experts. The following is an illustration of these five incidents:

> Incident 38 - Louise stated that as she was leaving Church on Sunday, her brother had arrived from work and asked her to stay with him for the meeting of another group. Louise had done so, and then had gone to her mother's home for a short visit.

An additional twenty-five of these "not significant" incidents were among those on which there was no agreement as to category (kind of information provided) by the psychiatric and

mental health nurses on the first or second rating. For the most part, these items were brief and varied in subject matter. They were descriptive of the patient's neighborhood (physical and social); brief interactions between the patient and family members or the nurse; interactions between family members and others; the patient's work performance; and comments by the patient about her family, her work, and attending church. For the most part, these incidents appear to the investigator to be as the psychiatric nurse expert stated: "Sterile." There appears to be little in them which would provide a basis for understanding dynamics of behavior, recognizing conflict areas, or planning patient care.

The remaining twenty-four incidents which were selected as "not significant" by the psychiatrists had been rated as both "significant" and in "agreement" as to category of information by the nurse experts. The two incidents below (given with the categories in which they were placed by the raters) are examples of these:

Incident 31 - Louise was sitting on sofa when nurse arrived. She sat silently while her mother was in the room, but stood and walked over to the overstuffed chair after her mother left the room and sat there during the remainder of the visit. (Across the room from the nurse.) Louise started talking about television programs. (Category VII)

Incident 190 - Betty said she had been unable to locate a place to live near the school and was afraid she would "have to move in with her mother." She said, "In some ways I think it might be good, really, and yet -" There was

quite a long pause, and then she said, "I know - I can see that I became quite dependent on - She stopped, looked down, then said, "I'm afraid I might - in fact, I think I already have - transferred some of this dependency to my mother and I'm afraid I might get back into it." "I was always too dependent on my mother, and while I was in therapy before I worked on it. I was dependent, even if I didn't love her. And she - well, she encouraged this. But I sort of got out of that, but now - I'm a little afraid I may get back into it again." (Category II)

Certain differences between the ratings of the psychiatric and mental health nursing experts and the psychiatrists have been noted and empirically analyzed during the previous discussion of the categories and the kinds of information obtained by observation of the psychiatric patient in the home which were included in these categories. Some further discussion of these differences, of the reasons for them, of the limitations of the findings of this study, and of general observations and inferences which were made during this investigation seem to be indicated at this time. These following comments and observations, like all preceding discussions, are based on the observations and assumptions of one person alone, and cannot be considered conclusive. Any of these, to be considered reliable, would have to be confirmed through further study.

<u>Differences Between Ratings by Psychiatrists and Psychiatric and Mental Health Nursing Experts.</u>

The major difference found by the investigator during

the analysis of the data was in the "kinds" of information suggested by the two groups as having been obtained by the observations of the patients in their homes. The categories suggested by the nurses seemed to be based more on what was actually observed by the investigator, such as interactions between the patient and others, between the family and others, comments about self and others, and feelings, thoughts and ideas by the patient without specific interpretation as to the meaning of this data. On the other hand, the kinds of information obtained through these observations which seemed "significant" to the doctors were mentioned by one or both to be in relation to diagnostic factors such as the dynamics of the patient's behavior, dynamics of and for the illness, appraisal confirmation of conflict and problem areas, recognizing strengths and weaknesses of the patient, relating modes of patient interaction to social and environmental influences, discerning patient progress in therapy, and evaluating the patient-therapist "transference" relationship. These kinds of information could be and were classified within the framework of the categories suggested by the nursing experts and defined by the investigator. However, the actual value and depth (significance) of the observations were based on the kinds of interpretations which can validly be made from the data.

Several reasons might be given for this difference in classification between the nurse and medical groups. The first is that nurses are taught not to diagnose behavior, to interpret data in the process of observing and recording it. Nurses with psychiatric and mental health background do learn to consider the underlying dynamics of behavior in order to plan and provide therapeutic nursing care, but any interpretations they make are primarily for their own information and are not considered conclusive except insofar as they are verified by the psychiatrist or by later, more concrete, events. Patterns of interactions, such as mutual withdrawal, are usually interpreted as such by the nurses only after an accumulation of evidence which is indicative of this type of behavior in relation to a certain patient. This leads to the second possible reason for classification differences.

The data in this study, for the most part, did not present sufficient evidence for the nursing experts to feel that they could interpret the dynamics of behavior or the patterns of interactions. Some of the experts did indicate that they felt that the observations could be used as one basis for understanding and evaluating behavior, relationships, insight, or conflicts, and their influence on the patient's illness. The "kind of information" which became significant, then, was the actual observation of specific

behavior, of an interaction between two people, or of specific comments (such as in regard to religion, feelings for and about self and others,) which might be used as a basis for making assumptions and interpretations which could be utilized in planning effective nursing care.

The psychiatrists, on the other hand, were acquainted with the patients, their behavior, and many aspects of their illness. The described incidents, even if taken out of context, had more meaning to them dynamically and could be interpreted in that way. Also, the medical group has been given the responsibility of and taught to do such interpretations as one function of their role as a member and the head of the psychiatric team. This approach to any kind of information, if given adequate observational data, would then seem to be the "natural" one for the psychiatrist.

This suggests an area for further study in relation to observations of the patient in the home. Categories of information based on dynamics, such as those suggested by the doctors (and indicated by some of the nursing experts), might be defined and the incidents (possibly with additional background information on the patient, her family, and her illness) re-evaluated in relation to these categories. Further breakdown in terms of patterns of behavior such as withdrawal, aggressiveness, hostility, self-punishment and

of roles of family members, might then be possible and a rating scale devised which could be used for further study of the patient and his relationships and behavior in the home as these factors relate to planning therapeutic care.

On the basis of the findings of this study in relation to differences of categorization of the incidents according to the defined classifications, it would appear to the investigator that some observations provide significant information of a certain kind to members of one psychiatric discipline while not (or of a different kind) to members of another. A different focus on the roles of the various psychiatric team members may be one factor which influences a decision as to whether a certain incident is significant, and, if so, the reason for its significance.

Another factor in relation to this appeared to be that when a patient was known to one team member, certain observations became either more or less meaningful than they would to someone not acquainted with that patient. This was indicated by the differences in the number and kinds of "not significant" incidents as they were identified by the psychiatric and mental health nursing panel as compared with those so identified by the psychiatrists. An additional consideration here, of course, was the difference in definition of "significant" by or for the two groups. The nursing experts

each did their own defining by the way in which they perceived and sorted the incidents. Two of these experts commented that to them "significant" had the connotation of any information which would be meaningful in relation to understanding the patient and planning patient care. Not knowing the patients personally seemed to make any incident which might give clues about the patient as a person or as a social being, or about his family, "significant."

It also became apparent to the investigator that one aspect of an observation may provide more significant information than the entire incident (as was seen in the sections underlined, or verbally indicated to be meaningful, by the psychiatrists). This might be more true when the patient is already known to the person rating the incident.

On the other hand, incidents which were taken out of context, so to speak, were commented on by the raters as being too vague, general or apparently unrelated to dynamics to be definitely considered significant. For example, Incident 208 ("Betty came into the room and Mr. D. left the house.") was rated as "significant" but not in "agreement" as to grouping by three of the first group of nursing experts, but not by the other nurses. Four of the five raters commented that this incident might be either extremely significant or not significant at all. Without any knowledge of the patient

and her family, except that provided by the other incidents, and without any information as to what preceded this particular situation, they felt they could not really determine its meaning in relation to dynamics of behavior, typical patterns or modes of interaction, etiology of illness, or what it might mean in terms of planning patient care.

There was some difference between the number of incidents perceived by the psychiatrists as compared with those seen by the psychiatric nursing experts to present "new" or "significant" information in each of the categories. Except for information pertaining to socio-economic environment, the nurse-patient relationship, and patient's interests and hobbies, the psychiatrists selected from three to nine more incidents as providing significant information about each of the other areas. This might be partially attributable to the number of incidents on which there was lack of "agreement" following the first rating by a nurse group. One of the psychiatric nursing experts who categorized the incidents during the second stage of the study indicated that some of the "better" incidents which had been obtained from the observations were among those deleted because of lack of "agreement."

The list of incidents rated as "not significant" by the psychiatrists was much longer than that of the nursing group (fifty-four as compared to nine). As was previously

mentioned, many of these fifty-four were of questionable significance or were found to lack "agreement" as to areas of grouping during the first sorting. Psychiatric and mental health nurses who work with patients in their immediate environment and within the framework of the nurse-patient relationship are more apt to perceive observations relating to these areas as important. They might also consider certain incidents as significant for gaining insight into the patient's modes of interaction, patterns of behavior and expressions of needs in order to plan therapeutic nursing interventions which may or may not be of significance to the physician (whose frame of reference in therapy is frequently more geared to assisting the patient gain insight and work through conflict and problem areas).

Another major area of difference, both between the nursing and psychiatric groups and between individual nurses, would appear to be in relation to individual depth of perceptions. Much of this is influenced by the formal educational background and practical experience of the individual. Differences between the nurse experts in this area (as well as between psychiatrists, and psychiatrists and nurses) would seem to the investigator to increase the differences in the way an incident is perceived and categorized by the various raters. This might have been one of the major factors in

the variety, scope, and depth of suggested groupings by the psychiatric and mental health nursing experts who first sorted the incidents as well as in the original selection of incidents by the investigator for rating. The influence of these factors, as well as others, on the results of this study will be discussed with the limitations of the findings.

Limitation of the Findings.

Various factors have influenced, and therefore limited, the findings of this study. The subjective and exploratory nature of the research was conducive to producing errors and introducing variables which could not be controlled. The first of these factors was related to the patient sample. Since the patients were all working, the rotation of time of the visits could not be adequately controlled and this may have limited the kinds of interactions and behavior which were observed. The assumption about the female patient being in the home more than the male was not supported by this particular sample, and is possibly something that should be looked at in more detail in relation to frequency, diagnosis, and dynamics of mental illness or health. The fact that there was not an adult male figure (father or husband) living in the homes of any of the patients during the study limited the interactions which were observed and which are very important in many situations. Even so, more "new and significant" information about patient-father relationships was

obtained by the home visit than had been presented in the office interview by both of the patients included in the incidents which were studied.

The variation in frequency of home visits to the different patients may have influenced both the kinds of information obtained through observation and the ability of the participant observer to remain objective (especially in relation to patient B., who was more acutely ill, suicidal, and indicated a need for a great deal of support throughout the entire study). The observer did attempt to place some controls on this factor by specifying the number of visits to be made to all of the patients for purposes of the study. However, this control may not have been adequate and further study is needed to determine the influence of frequency of visits on the amount, kinds, and objectivity of information which is obtained through observations in the home.

The reason understood by the patient as to the purpose of the study influenced both the patient's expectations of nurse participation and the kind and amount of participating which the observer felt she must do. This, too, could have influenced the objectivity of the observer and may have limited the kinds of observations which were included in the recorded data.

Whether this same factor also influenced the kind and

amount of family interactions with the patient and between each other and others is not known. However, it was noted that adult family members did not enter into much observable interaction during the time the observer was in the home. This limited the extent of observations of patient-family and family-other relationships and the amount and depth of data which was obtained in this area.

Some consultation between patient B's psychiatrist and the observer became necessary during the course of the study because of the severity of her illness. Although it was felt by the observer that this may have been somewhat influential in relation to the kinds of data she looked for and/or recorded, it also seemed helpful in maintaining more objectivity as the observational data was related to and discussed somewhat by the doctor. This introduced another variable and an additional limitation on the findings.

Three times before the observer obtained the tape recorder, the detailed recording of the observations had to be postponed because of other responsibilities. Some notes were made however, soon after leaving the patient's home. The observer found that postponing the recording of the observations limited her recall and the extent and objectivity of her recording. Procurement of the tape recorder was of value in controlling this variable.

The selection of the incidents for further study by the investigator introduced another subjective factor. An interest in studying a variety of data (because of the topic of research) influenced the items selected for the data analysis, and also the decision to exclude the incidents from the observations of the third patient. It was also the desire of the investigator to include incidents which might be meaningful in presenting some kind of information to the psychiatric and mental health nurse experts and to the psychiatrists. Therefore, the incidents included in the study were seen by the observer as pertaining to many kinds of information and also as being somewhat meaningful. The way in which these incidents were perceived by the raters many times did not agree with the concept of the investigator. The determination of the categories for the final rating was somewhat influenced by this already formulated concept, as was indicated by the inclusion of the last four categories in the study. The selection of the cut-off point for "agreement" and "significance" was a control used to prevent influencing of the findings by the subjective ideas of the investigator.

The differences in perception as to what was significant, as well as depth and scope of the groupings suggested by the first psychiatric and mental health nursing experts,

also influenced the findings. They provided a form of control for the determination of the categories. However, they also limited the number of "significant" incidents included in the final rating because of overlapping of data included in the various groupings by the individual raters. A combination of the vagueness of the instructions for sorting (lack of direction as to the form which the sorting of the significant incidents might take, the number of incidents, the scope of the topics, the differences of backgrounds of the raters, and the lack of sufficient data about the patients (in relation to specific incidents or the entire set) were prohibitive barriers as far as any deeper analysis as to the dynamic factors which were involved.

The investigator's selection of the categories and of the groupings to be included under any one category also limited the final number of incidents to be rated. Broadening some of these categories (such as incorporating IX with I, II with III or III with XI, IV with V, and/or X with XII) might have prevented some of the overlapping of the categories, and the difficulty which the experts stated they experienced in rating incidents which they felt included more than one kind of information. From the data mentioned in relation to the re-rating of items on which there was "no agreement" during the first rating, the investigator inferred

that some of the incidents deleted because of this lack of agreement might have presented significant information pertaining to the last four categories. This assumption might be based on investigator bias, however; and all four of these categories, because of the limited number of items included in each, should be refined, re-studied or incorporated into other categories.

Inclusion of the psychiatrist's ratings of "significant" and "new" information strengthened the categories previously selected. However, since their concept of the importance of this data was somewhat different, their own selection of categories would have been more meaningful to them, and also would have provided another and perhaps more significant way of evaluating the data obtained.

One other limitation of the findings is based on the size of the sample, the number of experts and psychiatrists involved and the cut-off point (two of three raters) for agreement as to category in the final rating. Because of these factors, generalizations cannot be made about the inclusiveness or exclusiveness of the selected categories or of their significance to members of the psychiatric team. It would seem, however, that observations of these kinds of information (as defined by the categories), if done objectively, do provide data from which significant information

relating to the dynamics of the patient's illness, patterns and dynamics of behavior, modes of interaction, areas of stress and conflict, needs, ability to relate to and with others, relationships with the psychiatrist and the psychiatric nurse, and progress in therapy can be obtained which will be helpful in planning and providing therapeutic patient care.

General Observations and Inferences.

Several general observations were made about the patients and their families during this study. First, it was noted that on the first visit to each home when someone responded to the observer's knock (both in the pilot and sample groups), the nurse observer was not invited into the home. In three of the six visits, the patient was not at home. In a fourth, the patient was still in bed (at 11:00 A.M.). Each of these times, the family member answering the door remained behind the screen and kept the door partially closed so that the observer could not see into the house. In the other two situations, the patient herself answered through the closed door and asked the observer to come back another time. Inferences which might be made from this are that (a) the illness of the patient and/or family members might include a fear of strangers or create some feelings of apprehension about allowing a nurse from the Mental Hygiene Clinic into

the home, (b) the physical appearance and condition of the home was such that the patient or family member did not wish others to see it, or (c) if the patient was not at home, the family felt the "nurse" would not be interested in staying (i.e., that she was only coming to visit the patient).

The second general observation was that the adult family members of patients included in the study seldom came into or stayed in the room where the patient and investigator were talking. This may have been due again to feeling that the "nurse" had come for the purpose of seeing only the patients. However, it was noted that toward the end of the study, there were more interactions between the patient and these family members, and that the family members did come into the room and talk with the observer for short periods of time. It was the impression of the investigator at that time that these family members may have been threatened by the presence of a "psychiatric nurse," and needed to observe and test her before exposing themselves too completely to her. As they became more comfortable with her and with her visits, they seemed more able to participate.

In many of the observed interactions between the patient and family members, there was either a lack of verbal communication or attention was focused on the needs or requests of the latter. During verbal interactions between

the family and the observer, it was noted that the discussion was primarily centered on the interests or problems of the family members. This was also noted during visits to one of the pilot samples and to the patient which was later excluded from the study. From the above-mentioned observations, the investigator inferred that in these situations, at least, problems or emotional needs or disturbances of the other family members may have been so great that they might be an obstacle to the patient's recovery. It would seem that diagnosis of other family members or of the family as a group, with a plan for therapy in the clinic or home, might well be indicated in these situations.

The fourth general observation made during the study was in relation to receptivity toward the nurse observer's visits by the patients. In the one situation when the illness was more acute (Patient B.), the patient twice requested the nurse observer to make a visit and appeared to be anxious to have frequent visits to the home. Both of the other patients were more reluctant about the visits and each twice postponed visits because of "other plans." Whether this difference in reception is related to the acuteness of the illness is unknown. However, if a psychiatric nurse were to function in a program of patient care in the home, this might be a factor to study in more detail.

It has also been noted in the recorded incidents that both patients A. and B. moved from their homes to other places of residence during the course of the study. The significance of this in relation to the observational visits is questionable, and yet there is a possibility of correlation between these two factors. Patient B's move was forced by the condemnation of the apartment house for the construction of a highway. The length of time permitted following final notice to move was only one week. However, this patient had been aware that this would be happening but had been unable to take steps toward locating another home or apartment. The move to her "mother's home" during an acute phase of depression and just prior to a suicide attempt could be quite significant in terms of the impact of the nurse's visits to her home.

In the case of patient A., she stated she had "tried to move" a year before, but this had not been successful. Shortly after the observational visits started, this patient began to actively look for a place to live in the city, and the actual move to a room above the investigator's apartment approximately seven weeks after the visits were started again seems to have some significant implications. How these two factors (moving as related to the home visits) are correlated is questionable, and the observer knows of no way this might

be further studied. However, a research study might be implemented whereby a psychiatric nursing program providing patient care in the home could be evaluated in terms of observable changes which occur in the patient or the family during the course of such a program.

Another general observation was that the investigator had some difficulty in maintaining the role of objective observer throughout the study. Possibly her recognition of a dual role was influential in making this more difficult. Although an attempt was made to confine the participation to a supportive type, the observer was frequently aware of looking for or finding clues about the development of nurse-patient relationship, patient needs and conflict areas in which therapeutic intervention might be helpful. It was her feeling that significant research in psychiatric nursing might be done in relation to the patient who is at home, such as defining and meeting patients' needs, providing therapeutic nursing intervention, or development of the nurse-patient relationship in the family setting. Any or all of these might contribute to providing a therapeutic environment in which the patient - and possibly the family - would be able to grow emotionally.

Summary of the Kinds of Information Obtained by Observation of the Psychiatric Patient in the Home.

On the basis of the ratings by the psychiatric and

mental health nursing experts and the psychiatrists, it would appear that the broad areas in which the greatest amount of significant information is obtained by observation of the psychiatric patient in the home are those which relate to the patient's relationships, including: relationships and interactions with other individuals, namely children, parents, and siblings, the nurse observer, and others outside the family; his self-concept; his problems, needs and conflicts; and his physical and socio-economic environment, in that order.

There was very little agreement by the nursing experts on the inclusion of significant information relating to the family members' attitudes toward self and others and relationships with others (excluding the patient). Whether this was due to a limited number of incidents describing such interactions or relationships, the quality of those incidents, or the interpretation of the experts as to what was "significant" information about a patient could not be determined. However, the constant focus of both psychiatric nursing and psychiatry on the individual patient, and other factors as they relate to the patient, would indicate to the investigator that the family members' attitudes and relationships might be one of the most important. If diagnosis, nursing care and therapy are to extend into the home, then the focus would have to be broadened to include each family member in his own right, as

well as in the context of his influence on the patient.

The last four defined categories were very limited as to the extent of information included by the nursing experts. This might be indicative of doubts as to the significance of these kinds of information or of overlapping of the categories. However, in reviewing the categories, the doctors commented that observations of the patient at work in stress situations, and also in relation to "things" (rather than people) provide very meaningful data which should not be overlooked.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The recent trend in psychiatric care has been directed toward treatment of the mentally ill patient in the local community hospital with early discharge and psychotherapy, drug therapy, or electroshock therapy on an outpatient basis. Increasing emphasis is therefore being placed on the family and environment in relation to precipitating factors and prognosis of the illness. Some studies are now being done in which family diagnosis and treatment are given concurrently with individual patient care. This shift in emphasis suggests a need for the psychiatric nurse, who has as one of her concerns the promotion of a therapeutic environment for the patient, to study the patient and family and to begin defining the role of nursing as it relates to care of the psychiatric patient in the home setting.

The present study was designed to discover the kinds of information which may be obtained by observing psychiatric patients in the home setting and which may be significant to psychiatric and mental health nurses and to the psychiatrist in gaining insight into the patient's illness and in planning therapeutic patient care.

A review of the literature in the field of psychiatric

nursing, public health nursing and related areas indicated a paucity of information about or studies relating to the mentally ill patient in the home. Some studies have been directed toward diagnosis of the entire family, sometimes with the use of a home vist or of concurrent treatment of other family members in the clinic setting. No studies were found which were concerned with the specific kinds of information which can be obtained by use of observational home visits, or with patient care in the home setting.

The method selected for this exploratory study was the use of an analysis of insight-stimulating cases. The patient sample was selected by the psychiatric staff at the Utah Mental Hygiene Clinic. Twelve observations were made on each of three female patients who were diagnosed as mentally ill, living at home, and being followed in outpatient therapy.

The data was recorded in detail and two hundred and twelve incidents were selected from the mass of raw data for analysis. These incidents were placed on five-by-eight cards and sent to seven psychiatric and mental health nursing experts for sorting into groups by significance and similarity. Rating and classifying was completed on five sets of incidents and the resultant groupings were used as a basis for evaluating significance of the incidents and for selecting categories which might identify the information collected

during the investigation.

The incidents considered to be "significant" and in "agreement" as to the kind of information they provided were sent, with the categories selected as a result of the original groupings, to three additional psychiatric nursing experts for classifying. "Agreement" as to the kind of information any incident provided was based on similar categorization by two of these three raters.

All of the incidents, along with the categories, were also given to the psychiatrists of the patient sample for rating as to significance and newness of the information to the psychiatrist and for categorization.

By studying the results of these ratings, it was hoped that the questions formulated for study could be answered. These questions were:

1. What are the types of information obtained by observation of the psychiatric patient in the home?
2. What kinds of information obtained by such observation are significant to the psychiatric nurse?
3. Is information obtained by such observation considered to be new and significant to the psychiatrsit?

No statistical analysis was done because of the nature of the study and the smallness of the patient sample and

rater groups. Certain generalizations were made on the basis of the findings which indicated that the greatest amount and most significant kinds of information which were obtained by the observations in this study were in the area of the patient's relationship with significant others in her immediate environment, and in relation to her self-concept, and her needs, problems and conflicts and the way in which she was attempting to work through or resolve these.

CONCLUSIONS

Even on the basis of the small patient sample, the findings of this study were indicative of certain factors. First, the following kinds of information are obtained which are significant to both psychiatric and mental health nurses and to psychiatrists in terms of gaining understanding and insight and in reaction to planning patient care:

1. Patient's relationship with family members (parents and siblings).
2. Patient's attitudes toward child-rearing attitudes and practices and his relationships with children.
3. Patient's relationships with individuals other than the immediate family.
4. Patient's relationship with the nurse observer.
5. Patient's concept of self and feeling for self in relation to others.
6. Patient's needs, personal problems and conflicts, and the way in which he is attempting to work through and resolve these.

7. Patient's physical and socio-economic environment.

Findings were suggestive, though not as strongly, that the following four areas as they related to patient care are also significant to the nurse and doctor groups, and that information about the patient or family in relation to these areas can be obtained by observation in the home.

1. Family members' attitudes toward self and others, and relationships among selves and with others (excluding the patient).
2. Patient's and family members' attitudes toward and relationship to pets and inanimate objects.
3. Patient's work adjustment and performance.
4. Patient's and family's reaction to stress and "crisis" in the home.

One other area tentatively considered by the researcher as being significant was not verified by the ratings of either the psychiatric nursing or psychiatrist groups. This category was the "Patient's interests and hobbies."

There was also indication, based on the agreement by both psychiatrists, that information which is both "new" (formerly unknown) and "significant" to the therapist can be obtained by observation of the patient in the home. The amount and significance of "new" information which was obtained by the observations of both families supported the previously formulated, but untested, theory that information could be obtained by observation of psychiatric patients

and their families in their homes which was not procured in the hospital or clinic setting. The findings of this study, though not conclusive, stressed the need for further research in this area.

OTHER CONSIDERATIONS

The information obtained in this investigation is merely a beginning step in studying factors relating to the psychiatric patient in the home. Each of the categories need further refining and study. The psychiatric and mental health nursing experts indicated an interest in examining the data from the standpoint of patient and family dynamics as they relate to planning therapeutic nursing care for the patient at home. The psychiatrist's selection of "significant" and "new" incidents based on dynamics of their individual patients indicates that breakdown of the categories in terms of dynamic factors such as modes of interaction, roles of various family members and dynamics of behavior, might be possible and add significance to the observational process and facilitate the use of such information in planning patient care.

The data and findings also suggest stimulating questions from which other research studies might be done relative to patient and family diagnoses, affectiveness of therapeutic patient care in the home, response of the patient

and family members to home visits by a member of the psychiatric team, and the role of the psychiatric nurse in the care of the mentally ill patient in the home environment. All studies in this area would necessarily be of an exploratory nature at first because of the limited number of previous studies, the subjective nature of this type of research, the number of uncontrollable variables, and the difficulty in providing effective controls.

The categories which were selected as pertaining to significant information about the psychiatric patient and his family could have practical value in providing a guide for observation, recording and reporting for individuals who already have a responsibility to the patient in the home. In order to use the findings as this type of guide, they should first be used as a basis for inservice education around methods of objective observation and recording, important areas for observation, and the kinds of observed incidents which are of significance to members of the psychiatric team.

QUESTIONS RAISED BY THE STUDY

Certain questions were stimulated by this study and are presented here for further deliberation by the reader. Directly related to the findings of the study are questions relating to information about psychiatric patients and their

families. The following questions are in this area:

1. Is there a distortion or an omission of significant information given by the patient or family during interviews in the clinic or hospital setting?

2. Are there differences in the kind or completeness of information obtained by observation of the patient and the family in the home as compared with information procured in the hospital or clinic setting?

3. Is there a method of categorizing and recording information obtained by observations of the patient and family whereby such factors as patterns of behavior, modes of interaction, or roles of family members might be identified and used as a basis for making a family diagnosis and for planning family therapy?

4. Is more than one home visit required to obtain significant information about the patient and his family? If so, is there an optimum number of home visits for securing such information?

5. Does the degree of significance of information about a psychiatric patient as perceived by various members of the psychiatric team differ with the role of the team member and the way in which the information might be used by each in planning patient care?

6. Can someone other than one of the present members

of the psychiatric team, such as a public health nurse, observe and record data which will be of significance to the psychiatrist and other team members in planning patient care? If so, of how much value would this be to the psychiatric team and the patient? How might this non-psychiatrically trained person be best prepared to fill this role? (These last questions seem especially pertinent because of the limited number of psychiatric personnel available at the present time.)

The kinds of information obtained about the patient, the family and their relationships and some of the general observations which were made have pointed up certain questions relating to psychiatric therapy. It seemed quite evident during this study that members of these families had many emotional problems, and were influential in the patient's illness and recovery. This factor reinforced the observer's personal opinion that in many situations, the psychiatric patient lives in a"sick" family environment. In a case such as this, certain questions are again raised:

1. Is family therapy needed to permit or promote the patient's recovery?

2. If family therapy is needed, who should provide this, and in what way?

3. Are visits to the home by one or more members of the psychiatric team of greater therapeutic value than treating

the family in the clinic or the hospital setting?

The lack of invitation into the home on the first visit to all of the patients in both the pilot and sample groups seemed somewhat unique to the observer. During her past experience in public health nursing, the observer had found situations in which an invitation to enter the home was not given; but these experiences were somewhat rare as compared with the universality of the situation found in this study. This stimulated the questions:

1. Do psychiatric patients and their families find it more difficult to permit visits into the home by an "outsider" than do medical, surgical or obstetric patients and their families?

2. Was the nurse's identification with a psychiatric clinic an inhibiting factor?

Another closely related factor which seemed somewhat unique was the lack of participation and interaction by other family members during the visits of the psychiatric nurse.

1. Is it more threatening to families of the psychiatric patient to have a nurse member of the medical team in the home than it is to families of other types of patients?

2. What kinds of reactions do family members have to visits to their homes by a psychiatric nurse and what is the result of this reaction (positive or negative) on their

interactions and relationships with the patient?

3. Since the family members seemed freer to participate later in the study, are a number of home visits needed in order to obtain significant information about the family which can be used for planning and in providing treatment for the patient and the family?

The last general area in which questions are raised by the study was in relation to nursing care of the psychiatric patient in the home. Certain changes seemed to occur in the patients' behavior or illness during the visits of the observer. Recognition of these changes invites the following questions:

1. How do visits of a psychiatric nurse influence the behavior, the illness or the recovery of a psychiatric patient?

2. What is the role of the psychiatric nurse in caring for the patient in the home setting?

3. Is there a therapeutic value in providing nursing care for psychiatric patients at home as a part of the total treatment plan?

4. What kinds of preparation, such as education and experience, are needed by the nurse who plans to provide therapeutic nursing care in the home? Does this preparation differ from that need to provide psychiatric nursing care in the hospital?

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The differences which the observer experienced in initial receptivity by the various patients stimulated other questions in relation to psychiatric nursing care.

1. Is the response of the patient to the home visit by a psychiatric nurse, or another member of the psychiatric team, influenced by the acuteness of the patient's illness?

2. Are visits to the home of patients of more therapeutic value during acute phases of the illness?

3. Does the type of illness influence the response of the patient to the visits of the nurse and the therapeutic values of such visits?

During this study the nurse observer participated largely in a "listening" or "supportive" role, and did not attempt to provide psychiatric nursing intervention. Even so, the patients stated that they found these visits to be helpful. Because of this, the investigator questioned:

1. Would a public health nurse, with some preparation or experience in understanding psychiatric problems or caring for psychiatric patients, be able to provide nursing services to the psychiatric patient and his family which would be of supportive or therapeutic value?

2. What would be the role of the public health nurse who was visitng the psychiatric patient and his family at home?

3. What kinds of preparation would be needed for a public health nurse to fill this kind of a role?

All of the questions mentioned above seem pertinent to psychiatric treatment and nursing care and should be given consideration as possible areas for future investigation.

RECOMMENDATIONS

It is upon the observations of the investigator during this study, as well as upon the findings, that the following recommendations are made:

1. Continued research should be done to further refine and develop each category so that more objective and systematic types of observation and recording might be done during visits to the home of psychiatric patients.

2. Research should be undertaken to determine: (1) initial reactions of patients and families to home visits by a member of the psychiatric team, and (2) methods of patient and family diagnosis in the home setting by members of the psychiatric team.

3. Research should be inaugurated which would investigate and define various aspects of the role of the psychiatric nurse in caring for the patient at home. These might include consideration of: (1) development of a nurse-patient relationship in the home setting, (2) recognizing and meeting

the needs of the psychiatric patient in the home, (3) determining indications for therapeutic nursing intervention, (4) ways of providing therapeutic nursing intervention for the patient and family in the home, and (5) response of the patient and family to therapeutic nursing care in the home as it relates to progress in therapy and prognosis of the illness.

4. Research might be undertaken to study (1) the role of a psychiatric nurse, working under the medical direction of and closely with a private psychiatrist, in visiting psychiatric patients in the home as a part of the treatment program, and (2) the value of nursing care in the home as a part of total patient therapy.

5. A five-year research grant should be requested whichshould enable a psychiatric nurse with public health nursing background to study the role of the nurse in providing therapeutic nursing care to the psychiatric patient and his family in the home.

6. Research might be developed which would investigate: (1) initial reactions of patients and families to home visits by a member of the psychiatric team, and (2) methods of patient and family diagnosis in the home setting by members of the psychiatric team.

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APPENDIX

APPENDIX A

TABLE IV

NUMBER OF VISITS MADE TO THE HOMES
OF THREE PSYCHIATRIC PATIENTS BY TIME OF DAY VISIT WAS MADE

	Number of Visits by Time of Day			
Patient	Morning	Early Afternoon	Late Afternoon	Eveni
A	3	2	2	5
B	2	3	4	3
C	3	2	1	6

TABLE V

LENGTH OF OBSERVATIONAL VISITS TO THE HOMES OF THREE PSYCHISTRIC PATIENTS

Patient	Average Length of Visits	Shortest Visit Number	Shortest Visit Length	Longest Visit Number	Longest Visit Length
A	62 minutes	1	5 minutes	11	125 minu
B	75 minutes	1	3 minutes	8 and 12	135 minu
C	55 minutes	1	8 minutes	12	95 minu

TABLE VI

FREQUENCY OF VISITS TO THE HOMES OF THREE PSYCHIATRIC PATIENTS BY THE OBSERVER

Patient	Frequency of Visits Per Week		
	One	Two	Three
A	2	10	
B		6	6
C	8	4	

APPENDIX B

Instructions for Sorting Incidents

This is a two-sort process. The steps are as follows:

1. Sort all of the incidents in two piles.
   a. In one pile, place all of the incidents which seem to you to be meaningful or significant in some way.
   b. In the second pile place those incidents which do not seem meaningful or significant to you.

2. When you have completed this sort
   a. Write the letter "M" on each of the cards of the incidents which you consider to be meaningful or significant.
   b. Put aside those cards which you do not consider to be meaningful.

3. Sort the significant cards, putting those which you feel go together, together. Make as many piles as you feel they represent.

4. Label the cards in each pile with the same identifying number (i.e., on the cards in pile number one, write a "1", on those in pile number two, write a "2", etc.).

5. On the top card of each pile, write why you think these go together. Write on any of the cards to tell more about this.

Please return all of the cards to the sender.

APPENDIX C

TABLE VII

AREAS OF SIMILARITY OF INCIDENTS AND NUMBER OF ITEMS INCLUDED IN EACH AS SUGGESTED BY FIVE PSYCHIATRIC AND MENTAL HEALTH NURSING EXPERTS

Expert	Suggested Areas of Similarity	Number of Incidents in Grouping
1	A. Incidents which might provide clues to nurse about state of patient-family relationship and possibility of problems arising in this area.	
	1) Patient-parent Feelings of love, rejection, hatred, guilt.	42
	2) Patient-daughter Patient-son Expressions of inadequacy as a parent.	28
	B. Incidents which might provide clues to nurse of the deep feelings and expressions of need for some recognition, acceptance, and love with some indications of what patient might be doing to obtain these.	36
	C. Incidents which might provide clues of the socio-economic status of the patient or the type of environment from which he or she emerges.	8
	D. Incidents which might provide clues to nurse that patient's problems may be emanating from some religious conflict.	10
	E. Incidents which might provide clues to nurse of the patient's deepest, most subjective kinds of feelings.	47
	1) Patient's level of self-esteem.	
	2) How patient views self in relation to others.	
	3) Patient's sense of inadequacy.	
	F. Incidents which did not appear to be especially significant or meaningful.	41
2	A. Meaningful in area of interpersonal relationships with individuals other than the immediate family.	21

TABLE VII CONTINUED

Expert		Suggested Areas of Similarity	Number of Incidents in Grouping
2	B.	Meaningful in examining interpersonal relationship of nurse interviewer and patient.	17
	C.	Significant in evaluating patient's interpersonal relationships with family.	49
	D.	Family's interpersonal relationships among selves and with others.	15
	E.	Significant in evaluating physical appearance and setting of home.	10
	F.	Significant relative to identifying problems regarding economic security.	15
		1) Judgment in work performance and money management.	
	G.	Situations indicating concern or possible stress areas regarding psychosexual development.	7
	H.	Significant in determining patient's attempts to identify personal problems and attempts to work toward some understanding and/or acceptance of	50
	I.	Not considered significant.	28
3	A.	Patient-"husband" relationship.	13
	B.	Patient-parents relationship.	28
	C.	General background.	11
	D.	Nurse-family relationship.	16
	E.	Work.	5
	F.	Self-concept and feelings for self.	29
	G.	Patient-other relationships.	29
	H.	Nurse-patient relationship.	26
	I.	Patient-child relationship.	37
	J.	Religion.	6
	K.	Not significant.	11
4	A.	Work relationships.	10
		1) "Testing-out" and maturing.	
	B.	Self-concept.	14
	C.	Value system regarding behavior-religious involvement and belief.	52
	D.	Nurse-patient relationship.	33
		1) Reaction toward "therapist."	
		2) Resistance.	
		3) Withdrawal.	

TABLE VII CONTINUED

Expert		Suggested Areas of Similarity	Number of Incidents in Grouping
4	E.	Fear and anxiety about illness - insight?	24
	F.	Environmental background.	10
		1) Socio-economic factors involved.	
		2) Feelings regarding area in which one lives and how one reacts to these factors.	
	G.	Patient-parent and family relationships.	37
		1) Rejection, dependency, acceptance.	
		2) Interplay of family relationships.	
	H.	Parent (patient)-child relationships - focused primarily on parent.	33
	I.	Not significant.	0
5	A.	Reflect the setting or environment in which the patient and family live.	10
	B.	Significant parental attitudes about themselves or reflective of their own value system.	8
	C.	Significant in area of family relationships.	32
		1) Mother.	
		2) Father.	
		3) Other family members.	
	D.	Significant in area of nurse-patient relationship.	25
	E.	Significant in peer relationship.	6
		1) Other girls and women.	
		2) Men.	
	F.	Significant observations regarding patient and work adjustment.	7
	G.	Significant data regarding patient's problem and conflict regarding "J" (her male friend).	9
	H.	Data related to social relationship within neighborhood.	5
	I.	Meaningful observation and data in area of patient's concerns, anxieties and fear about self or others.	20
	J.	Significant data of expressed concern and anxiety on part of patient in relation to her effect on her children or her concern about them.	7

TABLE VII CONTINUED

Expert		Suggested Areas of Similarity	Number of Incidents in Grouping
5	K.	Significant data of expressed concern and anxiety on part of patient in relation to anxieties around moving and not being able to get settled.	5
	L.	Significant data of expressed concern and anxiety on part of patient in relation to problems of finances.	3
	M.	Significant data in relation to religion and patient's conflicts and values.	6
	N.	Meaningful in relation to patient's interests and hobbies such as drawing, sewing, taking course at University, etc. - also interest in Church attendance.	10
	O.	Significant data in relation to patient (parent) - children relationship. 1) In regard to discipline and authority. 2) In regard to mother's concern regarding health of child. 3) In regard to other children.	22

APPENDIX D

Instructions for Categorizing Incidents

(Completed by Three Psychiatric Nursing Experts)

IDENTIFYING INFORMATION

The purpose of this research study is to determine the kinds of significant information obtained by observation of the psychiatric patient in the home. Each of the enclosed incidents have been rated as significant for providing such information by three or more of a group of five psychiatric and mental health nursing experts. The following categories for the kinds of information obtained were determined by the researcher, utilizing the suggestions of the experts after their initial rating of the incidents.

Your help, as another expert in your field, is now requested in validating the categories. Please read through the incidents and on each card mark the number of the category which you feel identifies the kind of information provided by the incident about the patient and/or family (if an appropriate category is listed).

CATEGORIES

The incident provides the kind of information which is significant for:

I. Evaluating the physical and socio-economic environment in which the patient and family live.

II. Contributing to an understanding of the patient's concept of self and feelings for self in relation to others.

III. Determining the patient's needs, personal problems, and conflicts, and the way in which he is attempting to identify, work through, and/or resolve these.

IV. Evaluating the patient's interpersonal relationships with family members (parents and siblings).

V. Evaluating the patient's child-rearing attitudes and practices and interpersonal relationships with children.

VI. Evaluating the patient's interpersonal relationships with individuals other than the immediate family.

VII. Examining the interpersonal relationships between the patient and the nurse observer.

VIII. Determining and evaluating intrapersonal attitudes of and interpersonal relationships between other family members (excluding the patient).

IX. Determining the patient's work adjustment and performance.

X. Determining the patient's interests and hobbies.

XI. Determining the reaction of the patient and/or family to stress or to a "crisis" situation.

XII. Evaluating the attitudes and relationship of the patient and/or family members to pets and extraneous objects.

APPENDIX E

TABLE VIII

CATEGORIZATION OF EACH INCIDENT FOLLOWING FIRST AND SECOND RATINGS BY A GROUP OF PSYCHIATRIC AND MENTAL HEALTH NURSING EXPERTS

Incident	Assigned Categories By Nurses Rating 1	Rating 2	Psychiatrist	Incident	Assigned Categories By Nurses Rating 1	Rating 2	Psychiatrist
1	1	1	1	26	7	7	NS
2	1	1	1	27	7	7	NS
3	1	1	NS	28	7	7	7
4	1	1	1	29	7	7	7
5	1	1	NS	30	NS		NS
6	3	3	2	31	4	7	NS
7	3	3	3	32	7	7	NS
8	3	2	2	33	NA		7
9	3	NA	NS	34	7	7	7
10	4	4	4	35	3	6	3
11	4	4	4	36	6	2	2
12	4	2	2	37	NA		6
13	4	4	4	38	NS		NS
14	4	4	NS	39	7	7	7
15	4	4	4	40	NS		7
16	4	4	4	41	7	2	7
17	4	3	4	42	7	7	7
18	7	7	12	43	7	7	7
19	NA		NS	44	NA		6
20	NA		2	45	NA		2
21	NA		6	46	NS		12
22	NA		2	47	NA		12
23	NA		2	48	NA		NS
24	NA		6	49	4	4	4
25	NA		NS	50	4	4	3

NA - No Agreement by Nursing Experts

NS - Not Significant

TABLE VIII, CONTINUED

Incident	Assigned Categories By Nurses Rating 1	Rating 2	Psychiatrist	Incident	Assigned Categories By Nurses Rating 1	Rating 2	Psych atris
51	4	4	4	78	NA		NS
52	4	4	4	79	NA		NS
53	8	8	8	80	NA		NS
54	4	NA	4	81	NA		NS
55	7	7	7	82	NA		NS
56	2	2	7	83	NA		8
57	NA		2	84	NA		6
58	NA		NS	85	NA		2
59	4	4	NS	86	3	6	3
60	NA		NS	87	7	7	7
61	NA		11	88	NA		3
62	NA		NS	89	2	2	2
63	NA		6	90	7	7	2
64	NA		NS	91	4	4	4
65	NA		NS	92	NA		3
66	NA		NS	93	NA		3
67	NA		8	94	NA		6
68	4	3	8	95	7	7	NS
69	4	3	3	96	NS		NS
70	4	8	8	97	NA		6
71	4	NA	4	98	NA		2
72	4	NA	4	99	3	6	NS
73	4	NA	4	100	1	1	8
74	4	3	4	101	8	8	NS
75	NA		NS	102	NA		9
76	NA		NS	103	NA		2
77	7	7	NS	104	2	3	3

NA - No Agreement by Nursing Experts

NS - Not Significant

TABLE VIII, CONTINUED

Incident	Assigned Categories By Nurses Rating 1	Rating 2	Psychiatrist	Incident	Assigned Categories By Nurses Rating 1	Rating 2	Psychiatrist
105	2	NA	11	132	5	5	5
106	2	2	2	133	3	5	5
107	2	3	3	134	3	2	3
108	1	1	1	135	2	3	NS
109	1	1	NS	136	5	5	5
110	NA		8	137	5	5	NS
111	NA		3	138	3	6	3
112	2	3	NS	139	NS		5
113	2	3	3	140	5	5	5
114	2	2	NS	141	3	2	3
115	4	4	NS	142	7	NA	NS
116	NA		NS	143	5	5	5
117	NA		5	144	2	9	9
118	5	5	5	145	5	5	5
119	5	5	5	146	5	5	NS
120	NA		5	147	5	5	NS
121	3	NA	2	148	NA		11
122	1	1	1	149	3	NA	NS
123	5	5	5	150	5	12	12
124	5	5	NS	151	2	3	NS
125	6	6	6	152	5	5	5
126	NA		6	153	5	5	5
127	NA		3	154	5	5	5
128	3	3	3	155	4	4	8
129	5	5	5	156	5	5	5
130	5	5	5	157	6	3	3
131	5	5	5	158	5	5	5

NA - No Agreement by Nursing Experts

NS - Not Significant

TABLE VIII, CONTINUED

Incident	Assigned Categories By Nurses Rating 1	Rating 2	Psychiatrist	Incident	Assigned Categories By Nurses Rating 1	Rating 2	Psychiatrist
159	5	5	5	186	3	3	3
160	NA		3	187	NS		NS
161	NS		NS	188	3	3	3
162	3	6	6	189	6	6	6
163	NA		3	190	4	4	NS
164	NA		5	191	3	2	5
165	NA		1	192	NA		4
166	5	NA	3	193	4	2	3
167	3	3	5	194			
168	2	NA	NS	195	NA		NS
169	NA		6	196	1	1	NS
170	NA		5	197	NA		NS
171	NA		NS	198	5	5	5
172	NA		9	199	3	3	3
173	NA		9	200	NA		1
174	3	3	3	201	1	1	1
175	NA		7	202	4	4	4
176	5	5	5	203	2	1	NS
177	4	4	4	204	4	11	11
178	3	5	5	205	NA		4
179	4	4	4	206	NA		4
180	NA		4	207	NA		8
181	NS		7	208	NA		8
182	3	NA	11	209	8	8	12
183	3	2	11	210	8	12	12
184	NA		3	211	4	12	8
185	3	6	3	212	3	8	

NA - No Agreement by Nursing Experts

NS - Not Significant

APPENDIX F

Incidents Illustrative of Information Obtained by Observation of the Psychiatric Patient in the Home

Incidents

1. The A. family live in a small, white frame house set back from the highway. The well kept front yard is covered by lawn with a few plants and shrubs near the house. On either side of the house is an orchard. Behind the house (some distance away) is a gray barn. The walk and small cement porch in front of the house were uncluttered and clean. The nurse was not able to see the interior of the house as she was not invited in.

2. The nurse was invited in to the front room of the A. home. It is a medium size room with a dull figured carpet on the floor. There is one window in the room. Beside the window is the front door. A couch is in front of the window, with a lamp beside it. The tops of the piano and cabinet were covered by a number of family pictures, one of Louise, the patient, one of her brother, one of her sister, wedding pictures of the sister and a married brother and pictures of their children. Along one wall is an overstuffed chair, a television set, a gas furnace, and a door leading into the kitchen. A door leads into Louise's bedroom on the south. Between this door and the front door is a treadle type sewing machine with a straight back chair in front of it. The room was clean and neat, the furniture was old but well cared for. In a large, clean kitchen was a big wooden table, a coal stove, a big sink and drainboard, a refrigerator and two or three chairs.

3. The nurse visited unexpectedly. Louise was ironing in the front room. There were freshly ironed shirts laying over the arm of the couch. The carpet appeared to be a little linty, and there were a few papers scattered on top of the sewing machine. However, the room appeared generally clean and uncluttered except for the equipment for ironing in the center of the room and the clean clothes on the couch.

4. After showing some dress patterns to the nurse and returning them to her room, Louise left the bedroom door open. There was a double bed next to the door with a pink spread on it. Across from the bed was a dresser with several small boxes stacked on top of it. There was an open closet in the corner by the dresser with several articles of clothing hanging on hooks and many articles of clothing on hangers. The room was neat and clean. There was no decoration in the room - no pictures were visible to the nurse. There was also a table with a portable sewing machine on it and a straight back chair visible to the nurse.

5. The family lives on the main highway on the outskirts of a small town near the city. A commutor bus stops in front of the A. home. There are three homes in the immediate neighborhood, with the A. home on one side of the highway and the other homes across from it. The homes are surrounded by farming land and orchards. All of the homes appear to be well kept. From the A. home one is able to see the Great Salt Lake to the West.

6. Louise was seated on the couch, sewing. She looked up suddenly and said, "Have I shown you the drawings I did?" Nurse: "No, I haven't seen them, but I'd like to." Marie got up and went into the bedroom, 45 seconds later she returned carrying two dittoed sketches. One was a picture of President David O. McKay of the L. D. S. Church and two unidentified children, the other of busts of George Washington and Abraham Lincoln. She said, "I did these for a church paper. It comes out once a month and I'm the Ward artists and do the covers for it. I have to do another one tonight because they have to have it tomorrow." Her face was slightly flushed and she looked at nurse all the time. She continued, "I don't go over there to Church very often. I guess I should more, but - well, I just don't like to go there very much." She then commented again about the pictures, and then put them away.

7. While talking about Sandra, the girl whom she hoped to live with in the city, Louise said, "The girl is very religious and I haven't gone to Church very much myself lately. I guess I'll have to start going more often". She continued to look down as she said this her face flushed. She rubbed her eyes, paused, and said, "I guess it really is a good thing." When the nurse asked if she felt it was really better to go more often, she replied, "I feel better when I go, and I think maybe if I move in there I'll go more often than I do out here.

I don't want to go just because she (Sandra) thinks I should. It isn't a very good reason for going to Church."

8. Since moving into the city, and living directly over the nurse's apartment, Louise has attended both "Sunday School" and "Sacrament Meeting" in Church each Sunday. When the nurse asked if she would like to do some art work for this Ward also, Louise said, "Oh, I don't know. I don't think they need an artist here, do they? I'll bet they have so many already". Her face flushed slightly at the suggestion, she twisted her hands and her body seemed quite tense. Then she added, "I think I'd just kind of like to go for a change".

9. Louise was talking about the Ward of the L. D. S. Church which her brother attends in the city. "I guess I'll probably go to that one if I go. I guess I should. Well, I really do like to go, except that out here I just haven't. Somehow it's different. The people are nice, and yet - well, I just don't like to go here. I really don't know much about the Church - not like I should anyway. Sometimes things seem kind of different and a few things I don't quite understand or maybe I just don't know about them." Her arms were folded as she made the last comments, her face became flushed and her body tensed. She then changed the subject.

10. Mrs. A. walked out through the kitchen door as Louise was entering. They did not speak to each other at all.

11. Louise talked a little about other family members. She said her father is working and living in a small town about 25 miles away, and that she does not see him very often, "and I'm glad about that because I don't like to be around him anyway." She planned to look at an apartment "in a few days," and said her brother was going to try to find someone for her to live with. Mentioned fear of trying to live with someone she didn't know, but did not discuss it very long.

12. While nurse and Louise were talking in the front room, Mrs. A. looked in from the kitchen, answered the nurse's greeting, then closed the kitchen door. Louise looked in the direction of the kitchen, then turned back toward the nurse smiling slightly but saying nothing. There was a slight crease in her forehead, she ducked her head slightly and then raised it again. A slight smile stayed on her lips for about 45 seconds, then she started talking abruptly about something that bothered her - a feeling that when people are talking, they are talking about her all of the time.

13. Mrs. A. was in the living room talking to the nurse about rhubarb, Louise looked down at her sewing silently. Mrs. A. left to get some rhubarb. When the nurse asked Louise if Mrs. A. had to go outside to cut the rhubarb, Louise just nodded. The nurse then expressed some concern about Mrs. A. going out when it was so dark and cold and windy, and Louise said, "Oh, she's been out there all day," then laughed. Then she added, "she never picks it to have on hand until she's ready to give it away or use it and then she picks it." There was a pause for 30 to 45 seconds and then Louise again started talking about her work.

14. Mrs. A. went through the living room twice. Louise stopped talking each time, glanced at her mother, then looked down, smiling slightly. Louise was talking about her work when Mrs. A. returned to the front room with some rhubarb in a sack for the nurse. She continued talking for about two minutes without looking at her mother. Mrs. A. stood by the straight backed chair and did not speak until Louise was silent, and then she spoke directly to the nurse.

15. The nurse was walking toward the house and Mr. A. was working in the garden beside the path. Louise hurried out of the house toward the nurse. She did not look at her father as she went past him. He glanced at her, then away, then watched as Louise and the nurse walked back to the car.

16. Louise was discussing her feelings about moving. She said that both of her parents were upset about this move, that her mother cried all the time and even her father started to cry. "He gets real emotional. And I just left. When mother gets upset and starts to cry, then I feel really guilty that I shouldn't be leaving her alone out here. And I get afraid that I can't do it. I don't like my father and I'm really glad he hasn't been here much, because he and mother just fight all of the time. I don't like to be around them, and most of the time I just try to get away from them."

17. "Mrs. F. (the landlady's sister) is so cute - and so nice. We talk a lot. She (Mrs. F.) told me that her daughter calls her twice a day, every night and every morning, and that she thinks every girl should do that if they can - that it's really being throughtful." "Louise looked down, then said slowly, "Do you think - I mean, I guess it is a good idea, especailly when Mom's home alone so much of the time." When asked how

she felt about calling home since she had moved, stated, "Well, sometimes it's all right, but - oh, we almost always end up having a fight and then we both just get upset. I really get upset - and I shouldn't get mad at her but I do. She just doesn't seem to accept my opinion or ideas about anything."

18. As the nurse parked her car in front of the house, Louise came out through the front door and glanced at the car. Her face was flushed. She walked around the side of the house and disappeared from view. Louise entered the house through the back door. Her face was flushed, looked at the nurse and then down. Nurse introduced herself. Louise nodded, said Dr. F. had mentioned the nurse's visits. Speaking rapidly, Louise said, "Don't you want to come out and see my dog? The nurse agreed that she would like to and went out through the back door with Louise.

19. Louise stated that she would have to be careful about the apartment she rented because she couldn't afford to "pay too much rent." She added that she was afraid it would be too expensive for her to live in Salt Lake City, but that she thought if she were careful she could do it. "There are so many things I'll have to get if I move into an apartment, but I've been saving up a little so I could do it."

20. Louise had told the nurse that she thought she would buy a set of Rena Ware cooking utensils, and that she would pay for it on time. The nurse asked if this would run her short financially, and Louise said, "Oh no, I really make quite a bit. I make more than my sister did when she was working - quite a bit more. I'm sure I can do it."

21. Louise showed the nurse an ironing board (aluminum adjustable) and General Electric steam-spray-dry iron which she had bought when she moved, also a cabinet for her sewing machine, "I'll have the cabinet paid for in October, and I'm trying to save $10 a month so I can take a class in night school this fall too. If I'm careful I should be able to have enough money saved by then." She continued to talk about her desire to take a psychology class at the University in the fall.

22. Louise told the nurse that she was considering buying a set of Rena Ware cooking utensils because it really sounded good. She had found that she could pay just a little of the down payment at a time until she had the sewing machine cabinet paid for an then she would

have more to pay on the Rena Ware. "I'll have the cabinet paid for in October, and then I'll be able to finish the down payment of the other by Christmas. I'll be able to pay $11 a month on it then instead of $5 as I am now. I had to take a little of my tithing money and also the money for my tuition at the University to make the $15 deposit that he requires, but I think I'm going to do it."

23. Louise was sitting at the switchboard at work. She looked up at the nurse and said, "This job is really fun sometimes, but - well, when it's like this - it's been so slow this afternoon and there wasn't much to do, and the time really drags. Bob K. gave me some dictation over the switchboard yesterday and that was really kind of fun. I don't usually have a chance to do much of that. Jane always does it." She paused and looked up at the radio system over which music was being played throughout the store, then said, "If it wasn't for the music, sometimes I'd just go crazy."

24. Louise, in talking about attending a night class at the University of Utah, said, "I'd really like to take some psychology. I guess I'll only be able to take a class fall quarter though because I can't afford it in the winter. I don't know what I'll do in the winter without softball or anything." She paused briefly and then said, "I really like my job, the people I work with and everything, but there when I'd like - well - something different to do. It's just so easy most of the time and I feel like maybe I could be doing something more than I am. That's one reason I'd like to go to the University."

25. A light flashed on the switchboard. Louise excused herself, picked up a connecting cord and inserted it into the socket under the signal light. She answered "Switchboard," paused briefly, then inserted the matching cord into another socket. She then turned to the nurse and said, "That was hardware. They just wanted an outside line." There were two other calls connected on the switchboard. A light came on by the connecting cords, and a buzzing sound was heard. Louise opened the switch, listened, then disconnected the cords. This was repeated with the other calls on the board. At 5:30, Louise opened each switch one at a time, took the back cord and plugged it into the switchboard, then took the front cord and plugged it into an outside line, saying, "When the store closes I have to be sure that all the lines are connected with one of the store departments and with an outside line so that calls can come

in and go out." She then turned off a radio which had been playing over the intercom system, and put away some papers in a file. Her movements were quick and sure. She looked around at everything around the board, said "OK, let's go," and left the switchboard.

26. Louise walked over to the overstuffed chair away from any other furniture on which the nurse could sit and sat down. Her face was flushed and her voice was high pitched and words were rapid as she talked.

27. Louise stood immediately when the nurse said she was leaving. Nodded when the nurse mentioned she would be back. Walked the nurse to the door, then turned and went into the bedroom before the nurse left.

28. The nurse arrived unexpectedly at the A. home. The patient's face became flushed and her body tense. She looked at the nurse directly and asked why she had come without letting her know she planned to do so, because she felt she looked "so awful". Throughout the visit she remained tense, her voice was high pitched, her words rapid, and she frequently rubbed her eyes with her fingers.

29. The nurse waited for Louise as the store was closing and offered her a ride home, which she quickly accepted. The nurse asked Louise where the switchboard was located. Louise looked at her quickly and said, "Were you in the store? Why didn't you come and find me?" When the nurse explained she couldn't find the switchboard, Marie said, "Oh, it doesn't matter. Come and say "Hi" the next time you're in there." She then explained where the switchboard was located, adding, "It really is easy to find."

30. As the car in which the nurse and Marie were riding stopped in front of Louise's home, she opened the door and quickly got out, saying, "Thanks for the ride home," then closed the car door, turned and walked rapidly up the walk to the house without looking back.

31. Louise was sitting on sofa when nurse arrived. She sat silently while her mother was in the room, but stood and walked over to the overstuffed chair after her mother left the room and sat there during the remainder of the visit. (Across the room from the nurse.) Louise started talking about television programs.

32. The nurse asked Louise if she planned to be home the following Tuesday evening. She replied, "Well, yes, I guess so, but wouldn't it be better if - well - isn't it easier for you if you just come on the weekends?" Nurse: "Is it easier for you if I just come on the weekends?" Louise paused for about 30 seconds, then said, "Well, yes, I can get more things done and it is a little bit better for me." The nurse then asked if she (Louise) would be home on Saturday. She replied that she didn't know whether she was going into town or not. The nurse said she would call later to make an appointment to see her. She hesitated, than said, "Well you know I don't get home until 7:00." Her words were quite rushed and she looked straight ahead and opened and closed her hands constantly. The nurse said she would call her after 7:00 P.M. Then Louise said, "Well, all right," pausing between her words. The nurse opened the door to leave and Louise said, "Thank you."

33. The nurse asked Louise if she had finished a dress she said she was making at the time of the last visit. Louise said "No", I have three things started which I haven't finished yet. Would you like to see the pattern?" She looked directly at the Nurse as she asked. She leaned forward, her eyes brightened, and a little smile appeared on the corner of her lips. "I'd like to very much." Louise got up and hurried to the bedroom. She opened the door and left it ajar as she went in and turned on the light. She returned immediately with two dress patterns. "They are all cut out, but I really think the plaid one is going to be cute." After the nurse looked at them and commented, Louise took the patterns back and returned to the front room, leaving the bedroom door open. (This was the first time this door had been open during the nurse's visit.)

34. The nurse was humming as she walked up to the house. Louise answered the door. Her hair was mussed and she was without makeup. She pushed open the screen door and said, "Oh, are you alone?" Nurse: "Oh, yes." Louise said, "I thought someone was with you. What were you doing, talking with yourself?" The nurse paused then said, "No, I was humming". Louise said, "Oh," and laughed. "Come in and sit down and I'll be with you in just a minute." The nurse sat on the couch as Louise went into the bedroom. She returned carrying a cotton dress, and a needle and white thread and a pair of scissors. She walked over toward the arm chair, stopped, looked at the couch then at the chair. There was a lighted lamp at the side of the couch. She turned,

came over to the couch and sat down at the opposite end from where the nurse was sitting. She then started talking about the sewing she had been doing.

35. A man walked past the switchboard to a file behind Louise. She said, "Hey, Bob, I want you to meet someone." He did not look at her. Louise's face was flushed. That's Bob, the fellow I've told you about. He's really funny - and fun to work with. He's always coming over and teasing me". As Bob turned and started back Louise said, smiling, "Bob, come and meet this friend of mine." Her voice was louder and higher, her words rapid as she spoke. He came over to the switchboard and Louise said, "This is Bob S---. He works in the next department. And this is Miss H." Bob's face was slightly flushed. He said, "I'm happy to meet you," then turned and walked quickly away. His face was completely serious during this time. Louise watched him walk away. She was smiling constantly. She immediately started talking again about how much fun it was to work there, especially with Bob because 'he's such a character."

36. Louise was telling the nurse about finding a room, describing how she had located it. When the nurse asked if Sandra was moving in with her, Louise said, "No, she can't move right now. She's busy and thinks she'll be getting married soon. She'd have to move again and she didn't want to have to move twice and - well, I think we may try to go to a movie some evening together anyway. We never did get to see "Ben Hur", but Sandra had a special meeting.." She continued to explain why Sandra would not be moving in. Her voice was high pitched, her words rapid, her body tense and she frequently rubbed her eyes with her fingers.

37. Louise was talking about her new home. "I really think it's going to be easier than I thought. And Lynn (girl living upstairs) told me she'd stop by and take me to a Church meeting tomorrow, so I won't have to go to Church alone. I really want to go a lot over there. And Lynn seems so nice and friendly. She came in and just talked for about an hour yesterday after I was moved in. It really helped."

38. Louise stated that as she was leaving Church on Sunday, her brother Dick had arrived from work and asked her to stay with him for the meeting of another group. Louise had done so, and then had gone to her mother's home for a short visit.

39. Louise hurried out of the front door and almost ran down the walk toward the nurse. When she saw her car, she called out, "Let's go for a ride." Her face was flushed, eyes bright, body rigid. The nurse responded, "All right." Louise did not look at her father who was working on the lawn as she went past him. He made a comment to Louise, but she did not respond. As soon as the car doors were closed, Louise said, "I think you're going to be mad at me. I'm moving into the house where you live. I didn't know you lived there when I went to look at the room, or when I said I'd move in. I'm not just moving there because you live there. I can't rent the other apartment, but the landlady there told me about Mrs. M's house and I went over to see it. When I got home I was going to call you to tell you that I'd found a place and then I found out you live there too. Are you mad at me?" Louise looked straight ahead as she talked and her face was very flushed. Her voice was high pitched and words poured out rapidly. Several times she asked the nurse if she was "mad" about this move.

40. The nurse and Louise had been riding in the car and talking throughout this visit. When they arrived at Louise's home, she sat in the car talking for about ten minutes longer, then said, "Well, I'd better go in and let you go." She got out of the car, turned and walked up the path toward the house. She entered the house without looking back.

41. It was the first day after Louise moved into her new room. She greeted the nurse with, "I was really hurt when you didn't come and see me last night. I thought you were down there, and then you didn't come up and see me." Louise continued, "Mrs. M. (the landlady) said you were gone and usually were real late getting back. That made me feel better. I thought maybe you were really mad at me or something at first when you didn't come up."

42. Louise was hemming dresses (shortening them) when the nurse arrived. She continued with her sewing during the entire visit. On one dress, the nurse helped her determine the length of the skirt. As she was doing this, her face was flushed and afterward she glanced at the nurse, then quickly away saying, "Thanks a lot for your help." She again repeated this as the nurse was leaving the visit.

43. Louise started to make some crepe paper roses while the nurse was visiting. She said she had learned to make

them in the fifth grade. The nurse told her they were pretty. Louise made six roses, each with blossoms of three different colors. She then said, "Would you like them? You can have them if you'd like." Watched nurse closely as she asked. Blushed when nurse thanked her for them.

44. Louise stated that Mrs. M. (the landlady) "knows just how to handle girls. She knew just the right thing to say and do when I was so upset last night, and I really felt better afterward. I was lying on the bed with my face covered up when she came in because she told me once that she spanked girls at her house when they got homesick, and I was afraid that she's spank me. Then later I told her that and she just laughed and said she didn't do it when they hadn't lived here any longer than I have."

45. Louise was talking about playing soft ball and said that Lucy (the team manager) and her friend planned to pick her up after work and take her to practice. Then she added, "I told them about me - about my trouble in high school and going to the doctor - and - they acted kind of funny. Like - well - I don't know, but maybe they won't want me to play with them now."

46. A blond cocker spaniel puppy was tied by a rope to a board in the barn behind the house. Frolicked to Louise and jumped on her two or three times. Louise patted the puppy, picked it up and squeezed it, then put it down again. She commented, that the pup was about five weeks old, and that she had had it for only a short time. She then turned and walked out of the barn toward the house without any other comment. The nurse followed behind her.

47. The nurse asked Louise about her puppy. She shrugged her shoulders and said, "Oh, he's out in back tied up." She paused, then smiled and looked up. "I have to keep her tied up unless I'm playing with her. She's really cute." The smile left her face and she said, "Out here near the highway we have to be careful. We had two dogs get killed. It was - awful." Her voice had become low and rather hesitant. "I don't want it to happen to her. I don't have much time to play with her now that I'm working, but I like to be with it as much as I can. She's so soft and cute - and she runs and jumps on me and everything." She was smiling again as she said this.

48. Louise said, looking down, "I really don't do much around the house to help. Mother doesn't think I do anything at all, and I guess I really don't. I don't really mind doing housework, except the dishes and I don't like to do those at all. I really hate to do the dishes." Several times she repeated that she really disliked doing dishes and very seldom did them. "Anything to do with the dishes, even, I don't like to do. I even hate to set the table." There was a long pause during which Louise continued to sew.

49. Mrs. A. and Louise were in the front room watching television ("The Rifleman") when the nurse arrived. Mrs. A. answered the door, then again sat on the couch. At one time she commented, "I like to watch this show because the boy is so well behaved. He really knows how to be thoughtful and courteous and he always minds so well. I don't like to watch some of them because the children never do as they're told." She looked directly at Louise, then glanced at the nurse as she said this. Louise glanced at her, smiled slightly, looked down, then at the television again. She did not say anything.

50. Louise was talking about her mother's reaction to her plan to move to the city. "Well, a couple of days ago she was kind of upset. She cried. And when she found out I was going to see Dr. F., why she got real upset about that. She doesn't like it very well and she gets upset every time she finds out. She didn't used to say anything. I don't see him very often now, and then when she finds out I'm going in, she doesn't like it and she cries and fusses and it worries me."

51. Louise was talking about work when her mother entered the room. Mrs. A. stood by the straight backed chair and did not speak until Marie was silent, and then she looked at and spoke directly to the nurse. She did not speak to Louise at all.

52. Mrs. A. did not look at or speak to Louise as she walked past her twice. Two other times she entered the room and spoke to the nurse, but did not speak to Louise.

53. The door was opened by Mrs. A., the patient's mother. She stood inside the house with the screen door open about three inches as she talked with the nurse. When the nurse explained who she was ("a nurse from Dr. F.'s office), Mrs. A. said, "Oh--," there was a pause of about 1 minute, and she then said that Louise was at work and would be home about 7:00 P.M. The nurse said

that she would call Louise after that time, then said, "How are you?" Mrs. A. moved closer to the door as she replied, "I am doing quite well, but some days I don't feel too well." The conversation continued for several minutes, then Mrs. A. again mentioned when Louise would be home from work and said she would tell her that the nurse had stopped by. As the nurse turned to leave, Mrs. A. said, "I guess I should have invited you in."

54. Louise and the nurse were sitting in the front room, talking. The back screen door opened suddenly and Mr. A. ran in, calling out, "Fire!" Louise smiled slightly and continued talking. Mr. A. started to swear and Louise's face became flushed and she looked down at the floor. Her voice became higher and her words faster. There was the sound of running water in the kitchen and Mr. A. told Mrs. A. to "Hurry - it's on fire out there!" The nurse glanced toward the kitchen. Louise looked up at her, smiled and said, "Oh, that happens all the time when he's here. He's always setting the place on fire. I don't pay any attention any more." And she continued to talke about work, sewing, etc. When Mr. A. left the house, Louise's body relaxed.

55. Louise's hair was uncombed. She was wearing a long (almost to her ankles) unpressed dress with no belt, house slippers, and no makeup when the nurse arrived. While ironing brother's shirt, said, "You didn't say you were coming today. Why didn't you tell me? I don't like it when you don't let me know. I just look terrible." When the nurse attempted reassurance, Louise said, "Yes, but your hair is combed and you look all right. How would you like me to visit you if you were like this?"

56. Louise sat on straight backed chair during the nurse's visit. She looked down throughout the conversation, glancing at nurse only twice. Hands held in lap were moving almost constantly. Occasionally rubbed eyes with fingers. Commented one time that she was "shaking" because she was "so frightened".

57. Louise's brother, Stan, was in the front room. Louise was ironing some shirts for him. Stan smiled as soon as he saw the nurse, commenting to Louise that he had met the nurse at Church in the city. Louise did not answer, but nodded her head slightly. Her face was flushed and she continued to look at the ironing board. Stan stuttered and each time he spoke Louise's body tensed and her head dropped slightly. She finished

ironing the shirt, handed it to Stan, turned and went into the bedroom. She returned to the front room after Stan left, then asked the nurse how well she knew him and if he had told her about herself. Louise changed the subject after the nurse said he had not discussed her.

58. Louise said that Stan had found a girl with whom she might live in the city, but that she felt frightened about moving in with a girl she doesn't know. "What if she doesn't like me or I don't like her, or something. I sure hope it works out. I've talked with her over the phone, but I've never met her. She sounds really nice though." Louise made no response to this suggestion that the two girls might get together before actually moving in.

59. The nurse commented on the attractive moccasins which Marie was wearing. Louise smiled, flushed, and said "I just bought them today to wear around the house, and I really like them. She then showed a skirt, a bright colored blouse, a pair of white shoes and white jewelry she purchased for her sister. She said, "I just got these for her for Easter. She got so many new clothes for me while I was going to school." Her face was flushed and she looked at the floor.

60. Louise entered from her room and sat on the arm chair across the room from the nurse. She sat silently for a few seconds and then said, "Oh, did I tell you about Pat being fired?" Nurse: Yes, you mentioned it. Have you seen her since she left?" Louise: "No, she hasn't been back. She said she would come back and see us but she hasn't been back." There was a pause and the nurse asked how things were going at work. Louise said, "Well," then smiled and lowered her head, "pretty good right now." There was another pause.

61. Louise cleared her throat, there was a pause of about 30 seconds, then she described an incident which had occured at work which "upset me a lot." Mr. T. (the boss) had asked her to tell his wife, if she called, that he wasn't in. She did call, and when Louise said he wasn't in, she asked to speak to her son and then to Mr. T's secretary. After talking with them both, then Mrs. T. called Louise back and "bawled me out for about five minutes because I had lied to her." As she described this incident, tears cam into her eyes, she kept continually clenching and unclenching her hands and her voice would rise then drop, in volume, but remained constantly at a

high pitch. She had started to cry when Mrs. T. hung up. "Jane (the secretary) came over and took the switchboard so that I could have a few minutes to get feeling better". There was a pause of about a minute. "Everyone tells me not to pay any attention to her (Mrs. T.) - that she's really hard to get along with and even Mr. T. doesn't pay any attention to her any more." Then she changed the subject.

62. Louise looked up, smiled and said, "Hi," as the nurse and a nurse observer approached the switchboard. The nurse introduced Mrs. R. (the other nurse) and Louise said, "How do you do?" Louise described the various parts of the switchboard. As she did so, Mrs. R. walked a little distance away and Louise said, "Who is she? Is she a nurse too?" Her face was flushed, her eyes bright, her voice high and words rapid, her hands shaking. The nurse said that she was another nurse and Louise nodded, then started describing the intercom system.

63. Mrs. M., the landlady, told the nurse that Louise was upset and crying the night before and didn't want any supper. "She said her stomach was bothering her and she couldn't eat anything when she first arrived home from work." Mrs. M. thought that something had gone wrong at work and also, that Louise was upset because the nurse had not been up to see her. The landlady said she had talked with Louise for a few minutes, then told her that if she felt like coming out and visiting or eating after while to do so. In about an hour, Louise had left her room and joined Mrs. M. in the front room, had eaten some salad, watched television and Mrs. M. had taught her to play Solitaire.

64. Louise was describing an incident which had occurred at work, Mrs. A. came into the front room. The nurse smiled and said, "How are you tonight?" Mrs. A. said, "Oh", paused, then added, "Fine." She paused again for 45 seconds, then said, "Do you like rhubarb?" When the nurse said she did, Mrs. A. sat down and began talking about her rhubarb. She smiled as she talked and ended by offering the nurse some. Then Mrs. A. went outside to get them.

65. Louise and the nurse were talking in the living room. Mrs. A. entered the kitchen. She walked into the living room past Louise and the nurse and opened a door beside the piano. She went inside and quickly closed the door. While the door was open briefly, the nurse was able to

see only a large dark room, many shelves around the walls. After the door was closed, there was the sound of a light being turned on. Mrs. A. remained in the room for about two minutes, then again there was the click of a lightswitch, the door opened and Mrs. A. came out of the dark room and quickly closed the door tightly. She walked past Louise and the nurse carrying a big paper sack in her hands and went into the kitchen. She did not look at or speak to the daughter or nurse as she did this.

66. Mr. A. was working in the yard when the nurse arrived. He looked up, smiled and said, "Hello," as the nurse started up the walk toward the house. Immediately he returned to gardening, just nodding when the nurse commented about how warm it had suddenly become.

67. Mrs. A. was telling the nurse about helping with the Civilian Defense program and said, "I - well - I've got to go and visit all the people in this block and take them things and find out if they have anything ready. I didn't want to - it's kind of hard. I mean there's no time and so much to do, but my neighbor asked me and she's doing the whole program and - and she thought I could do it. She really talked me into it. And because she asked me, I told her I'd really try."

68. Louise was talking about going to Church when she moves to the city, "I - we - well, we haven't gone very much out here. We went a little more before we moved here but, - well, the people here are nice enough, but - Mother never liked to go because of the way she is - being crippled like that." (Mrs. A. has a severe back deformity). Louise looked down as she talked. "Of course, I don't blame her. But she didn't ever go to Church or wouldn't talk to the neighbors or anything. She always felt like people didn't like her and were looking at her and talking about her and I can see why she would. But she's started to go to the women's meeting now. The lady across the street asked her to go and comes and gets her, and so she goes. She said it's real hard, but it's getting easier. And she visits with that neighbor quite a bit now, too. And I'm glad because she's so alone out here and with me going it will be even worse for her".

69. Louise said she had been to a doctor because of having an infection and he had given her some medication. "I didn't tell mother about the sulfa because she took it once and it made her sick. She said it would make me sick too. She and my father don't believe in doctors. He says they're all no good and just out to get your money. But mother stands up for them sometimes. But

she is afraid to go to them, and doesn't like it very much when I go."

70. Mrs. A. was in the kitchen. Louise and the nurse were talking in the front room. Suddenly the back screen opened, Mr. A. ran in calling out, "Fire!" The screen door slammed and he again yelled "Fire." He glanced in the front room at the nurse, hurried over and closed the kitchen door. There was the sound of scurrying footsteps in the kitchen, and Mr. A. said, "For hell's sake, woman, get some water. Hurry it up. Don't be so damned slow. There's a fire out there." There was the sound of water running into a bucket, and Mr. A. again said, "Hurry - it's on fire out there." The water was turned off and there was the sound of hurrying footsteps in the kitchen and the screen door closed, more softly this time. Mr. and Mrs. A. did not return to the house again while the nurse was there.

71. Louise was talking about moving, "This is sure going to be a terrible week. I sure don't look forward to it. Mother will be upset and crying all the time. Since I'm going to be moving on Friday, the nearer and nearer it gets the harder and harder it's going to be. Mother said she knew something would happen to me with all those terrible men who are out to get the girls, and she says that one day the police are going to lock up all those terrible men." She looked at the nurse and said quickly, "That's what she said. She says things like that all the time." As she spoke she folded her arms and her body was tense. The nurse asked if her father was upset, and Louise said, "Oh yes, he's been real upset. He started to cry this morning. He gets real emotional. And I just left."

72. Louise commented in regard to working and being away from home from 7:30 A.M. to 7:00 P.M., "It's not really bad at all. I feel so much better since I've been working. I don't do much around her but then I never did do much. I - " she looked down as she paused, rubbed her eyes with her fingers, and continued, "I guess I should do more to help Mother. She has so much to do. I keep my own room clean and iron and keep my clothes fixed for work. That takes a lot of time. Sometimes I cook a little bit, or I did before I started to work. But Mother says I never do anything around here to help any more. And I don't do much."

73. Louise was talking about moving and of her fears about this. She said, "Mother's always done everything for me. I've just never had an opportunity to do anything

for myself, or to learn how to do things. She always told me I couldn't, or that maybe she should do it for me and that I never would be able to do things without her help. It really makes it hard for me to try to do anything when she's not there - or when she is." She paused, "She really feels bad about my moving. She doesn't want me to at all. She's afraid something will happen to me. What she'd really like is for the whole family to live together and never separate." Louise looked at the nurse and smiled, "Boy, wouldn't that be a mess, all of us in one house? We'd really have trouble then. But this is what she'd like, just to keep us all together."

74. Louise commented that her parents were getting along better together now than they ever had. "Maybe they could live together now and get along. And then this might be good for Mother. I never could get along with my father. None of us could. He was always so cross and he screamed and yelled at all of us and at Mother. And they always fought all of the time. She always stood up for me - tried to make things easier for us when he'd be like that. I just can't stand him. I've tried to like him but I just can't. And Mother said he feels really bad because I feel this way about him, but I just don't like to be around him. He used to scare me so much and everything."

75. Louise was talking about in work as switchboard operator and the others working there. Commented that she "loved the job," and seemed to get along very well with everyone. "Everyone's so nice and friendly that it's easy to make friends there." She commented that she felt "pretty good," but that she had "some trouble with allergies." Her comments were all made in response to questions. She sat quietly with head bowed, face flushed during both silences and conversations. Frequently rubbed her eyes with her fingers during the nurses visit.

76. Louise pointed to some pictures on the piano and cabinet. "My older brother and sister are both married. He has four children now, and my sister has three. He lives in a town about 25 miles away, and works up there so I don't get to see him very often. My sister is building a new home, way out in Murray or someplace. It really sounds like it's going to be nice. My other brother lives in the city." There was a long pause, then Louise added that her father was living with her oldest brother at the present time, because he is working there and

it was too far to come home. "My father comes down once in a while on a weekend and sometimes my brother comes out for a few minutes, but not for very long."

77. In response to questions or comments, Louise talked about her job, the kind of work she was doing, the job she had held previously, the fact that her "allergy" was not "bothering much" as yet, but that she had had to have shots for it last year. After a pause of 45 seconds, Louise said, "I don't know what I'm supposed to talk about you're here." The nurse replied that it didn't matter and Louise again paused 45 seconds, then started talking about her job and the people with whom she was working.

78. Mrs. A. answered the door after the nurse had knocked twice and had waited about four minutes. She said, "Hello," opened the screen door and said "Come in." She said Louise was out in back with the dog and would be right in, then turned and left the room (going through the kitchen and out the back door.) The nurse was left standing by the front door.

79. Mrs. A. was in the kitchen when Louise and the nurse entered the house. She did not speak. As they went into the front room, Mrs. A. went out through the back door. She did not return while the nurse was there.

80. Mrs. A. was on her hands and knees working in the garden when the nurse arrived. She looked up, smiled and said, "Hello," then started digging around the flowers again. She said nothing more. The nurse continued up the walk to the house.

81. Mrs. A. and Louise were watching television when the nurse arrived. As soon as the television program ended, Mrs. A. got up, turned off the television set, went into the kitchen and closed the door.

82. As the nurse entered the house at Louise's invitation, Mrs. A. looked into the front room from the kitchen, smiled and said "Hello," then closed the kitchen door (staying in the kitchen alone).

83. Mr. A., a small man wearing overalls and a work shirt, was in the orchard beside the house pruning the trees when the nurse arrived. He looked at the nurse, smiled and said, "Hello," as she approached. He commented "There's so much work to do all the time." He then walked away from the nurse to some trees which were further away.

84. "Things weren't very good earlier this week." Louise described an incident which had occurred in which she had suggested a new way of handling inside calls which came on the switchboard - a method which other companies use and which she felt would improve service for the employees. The suggestion had been presented by her at a staff meeting and was accepted by the employees. "But," she sighed and said, "I didn't tell Jane about it first and I guess I should have." All the time she was smiling slightly and appeared flushed. She continued to look down, occasionally glancing up, but looking down again immediately. Several times she rubbed her eyes as she described the incident. "Anyway, everybody liked it but Jane and Jane came up to me and was really nasty. She was really angry. She told me it would never work and that she would never use it. She was really upset about it and - well - after a day and a half I decided that since everybody wouldn't use it, why it wasn't going to go over and it wouldn't work. Everyone has to use something like this for it to work. Anyhow I just discontinued it." She continued to talk about the favorable reaction of others to the idea and the way in which Jane had reacted. "Since I discontinued it, Jane has been very nice again. She started speaking to me now again." Her mother then came into the house through the back door, and Louise stopped talking.

85. Louise stated that she and Sandra, the girl with whom she hoped to live when she moved, were going to get tickets to "Ben Hur". They had hoped to go this week, and Sandra called to apologize for not obtaining tickets but Louise said she thought this would really work out better because they would go to the matinee and it would be earlier when she got home. As she was talking, her face was flushed, her words rapid and her voice high. She constantly looked down as she talked.

86. At the checkout counter, Louise stopped and introduced the two nurses with her to the clerk. Louise then turned and walked quickly toward the door, with the nurses following. She introduced the nurses to two men standing near the door. As they drove away, Louise called out and waved to two men who were talking together on the sidewalk. The men were turned away from the car, but when Louise called to them, they turned and waved. During this time Louise was smiling brightly, face flushed, voice high pitched and quite loud, and her words poured out. She continued to look at the men as the car pulled away and repeatedly said: "They're so nice and friendly."

87. Louise had been talking about her work, then asked the nurse about school and whether or not she (the nurse) was working, too. She then said, "Well, aren't you working at a hospital at all as part of your practice or anything? Isn't that one of the things you're doing now?" When the nurse said "Yes", Louise said, "What do you have to do to become a nurse?" She also asked about becoming a psychiatric nurse. Louise said, "Well, you've been in here quite a while, haven't you?" What kind of work did you do?" The nurse replied, "Public Health Nursing". Louise looked directly at the nurse rather suddenly, her eyes opened wider and she said, "Oh, I thought that all Public Health Nurses were kind of old women." She added quickly that she had not known any personally, but had "always heard they were kind of old."

88. Louise said she "is afraid of many things, and sometimes I get upset with myself for being so afraid." She described an incident which happened when she was a child in which their dog had been hit by a car. She felt that the driver had deliberately tried to hit the dog because he had swerved toward it as he drove along. The driver didn't stop. "I saw the accident happen and saw the dog move afterward so I knew it was still alive. But I wasn't to move the dog out of the way of the traffic because I was afraid it might bite me. Then another car hit the dog and killed it." Louise stated that she felt very guilty about this - that she had not been able to carry it off the highway - and had never been able to tell anyone about it before because of the guilt feeling.

89. After discussing her fears about moving, Louise said that she really could tell that she was feeling a lot better since she had started seeing Dr. F. She said, "I feel this has really helped a lot and I can see changes in myself, although I still feel awfully immature and like I have a long way to go. I really want to get married and yet I wonder if I ever will be able to. Sometimes I'm afraid I won't - that I'm not and never will be ready.. And I get so angry so easy - just over little things. Sometimes I get scared because I get so angry." Again two or three times she commented about the fact that she felt she was much more mature than she had been when she first started therapy. "I feel I can do a lot more things myself and for myself, but sometimes it's still hard."

90. Louise stated that when the nurse first came to visit her, it was very difficult to talk about anything.

"Now, I feel it's easier to discuss some things with you than with the doctor because it's just kind of hard to discuss some things with a man - like sewing and cooking and a lot of things like that. I just feel kind of funny talking about stuff like that with a man, for some reason. And then I could tell you about when that dog got killed - you know, when I felt so guilty - and I couldn't ever tell anyone about that before. It's real hard for me to talk to anyone about things and sometimes I really want to. You know, just little things that happen. It seems kind of silly and yet they're important to me, too."

91. Louise told about an incident which occurred at work and which had been quite upsetting to her. As she was talking, Mrs. A. came into the house through the back door. Louise stopped talking as her mother came in and remained silent while her mother was in the house.

92. Louise said, "Oh, I'm fine," in response to the nurses' inquiry. There was a pause of several minutes. She kept looking at her hands and picking at her fingernails. She glanced at the kitchen door which was open, then again at the floor. The nurse asked if she was alone, and Louise said, smiling slightly, "Oh, no," and again became silent. Every 15 to 30 seconds she would rub her eyes with her fingers and then would again put her hands in her lap. She did not look at the nurse directly at all during this time.

93. Several small children were playing in front of a house across the street as Louise and two nurses were sitting in the car in front of the patient's home. Louise commented several times about how "cute" they are, and how well they play together. She said they already had four children in the family and the mother was pregnant again, adding, "Their mother told her husband after her fourth baby that if she got pregnant again she was going to move him down to the basement." She smiled as she said this, then again commented that the children were so "good" and "play together so well." She then changed the subject and commented about the sunset over the lake.

94. During most of the ride to the patient's home, Louise was silent or responded only in answer to questions or comments directed toward her by the two nurses. These questions and comments related to her job, the weather, and her plans for moving into town. As they

drove through Bountiful, Louise asked, "Did you know that Bountiful has more Juvenile Deliquents than any other city? It even has more than New York -- for the size of the town, I mean." When asked if she knew what might account for a high juvenile delinquency rate, she replied, "I'm not sure, but I guess it's because their parents let them run wild. They just don't seem to care what they do or where they go, and they just run wild." She then said she had spent two years at Bountiful High and one at Davis and said, "I liked Davis much better."

95. While riding home with the two nurses, Louise twice called the nurse by her first name. She suddenly turned to the nurse and said, "What is she doing?" She looked in the direction of the second nurse and said, "Have they assigned another nurse to the program?" Louise sat silently for a short time, then mentioned the neighbor children who were playing across the street. After a few minutes she turned to the nurse, her face flushed slightly and said, "I thought you were going to call this weekend." The nurse asked if it would be all right if she came on Friday, and Louise said, "Yes, I guess it will be all right." She continued to sit in the car, looking straight ahead but not speaking until Mrs. R. commented that she had an appointment in town. Louise got out of the car very slowly, said, "Good-by." She walked slowly up the walk toward the house, not looking back before she entered the house.

96. Louise named television programs which she enjoys watching - included "Gunsmoke," "The Rifleman," "Maverick," "Wyatt Earp," several other "Westerns," "Perry Mason," "I've Got a Secret," "The Ed Sullivan Show," and the news. Talked freely about Mayor Lee and Chief Skousen incident, saying that she didn't trust what Lee said at all. Also, talked about world news, Kruschev and some of the aspirants for office of the President of the United States.

97. Louise showed the nurse a drawing she had done of a kitten slipping off a stack of books. She said this was one of her best drawings and that she had made it in high school. The kitten looked realistic and Louise said the teacher told her it was "very good." She then asked the nurse if she had seen the picture of the horses which she had drawn for Dr. F. Louise suggested, "Why don't you ask him to let you see them. He thought they were pretty good."

98. Louise sewed all during the nurse's visit, hemming a

cotton dress. She commented that the dress was "Just to wear around the house." When the nurse said it was really "cute" and she might enjoy wearing it to work," Louise said, "Oh, it's such cheap material I don't like this kind of a dress for work. I just like to wear it around the house." She said that she likes to embroider, and knows how to knit "a little, but not as well as my sister." "I make quite a few of my own clothes, especially since I learned to put in zippers. I learned how once in the 8th grade, but it was always so hard and I always had the feeling that I wouldn't be able to remember the steps and everything. So I always had a feeling I wouldn't be able to make a dress with a zipper in it, but now they have directions on the zipper package and it's just real easy."

99. Louise stated that she had contacted Lucy (manager of a soft ball team) and was going to practice with the team. She hoped that if she became good enough she'd be able to play with them again. "I think I'll take a ball and my peddle pushers to work and have one ofthe men practice with me - let me pitch to them. This way I'll get lots of practice and maybe I'll get pretty good at it again." She was smiling as she said this. She showed the nurse some clothes she had purchased to wear playing softball.

100. Each time the nurse visited Louise and her family during the daytime, Mrs. A. (and Mr. A. when he was there) were working in the yard. The yard always appeared well-kept, there were flowers planted along the walk and the edge of the orchard. The lawn was always evenly cut. At one time Mr. A. commented, "There's so much to do out here all the time. It takes a lot of time and I work out here a lot."

101. Mrs. A. brought some rhubarb into the front room for the nurse. She then walked over to the sewing machine, turned to the nurse and said, "Do you know about Civil Defense?" The nurse said, "About Civil Defense?" Mrs. A.: "Yes, what they're talking about and you're supposed to do and everything?" Nurse: "Just a little. Are you interested in Civil Defense?" Mrs. A.: "Oh, they asked me to take this block - go and see all the people and give them things and everything. And - well, it seems like a person's so busy all the time. It's just too much. But my neighbor is in charge of this area and she asked me to do it and I said I'd try."

102. In commenting about work, Louise said that Pat, one of the other employees, was afraid she was going to be

fired. There was a long pause, then she added that if Jane (a supervisor) "got it in for you, then you were sunk. And she had done this before - with the last switchboard operator. Of course, everyone tells me I'm doing a really good job, especially since I haven't been there very long. And Jane really seems to like me, so I guess it'll be "O.K."

103. Louise questioned if the nurse thought she was "dumb," and if what she said and her ideas made sense and were "all right." Said that she sometimes fet very "immature" in her thinking, and also sometimes wondered if she really was intelligent at all."

104. Louise discussed fears about moving away from home, stating that she had a feeling that she shouldn't move, but that she only had this feeling when she was at home with her mother. "Whenever, I'm away, like at work, I don't feel afraid and I'm quite anxious to move." She said she felt guilty about leaving her mother "alone out there like this," and also felt afraid because "Mother keeps telling me I won't be able to do anything without her. I already feel so inadequate, I'm really afraid. Maybe she's right. I just don't know how it will be when I move." "My brothers and sisters feel that I should move - that it would be better for me if I do. It helps to know that they feel this way."

105. Louise commented about being afraid of living alone, and said she wondered if it could possibly work out. "I'm afraid about everything really. I just don't know if I can do it. Maybe it will be better living there, because I can have my board there and I've even been afraid about going into the grocery store, that I would get the wrong things or something. And I didn't see how I could cook all the time for myself. I have cooked at home and did all right, but somehow I'm afraid that I won't be able to do it when I'm alone. But at least I won't have to do that now."

106. Louise said, "I feel like I'm really immature and that I'll never grow up - like I'm so much younger than others my age. Can you ever make it up when you don't have a chance to grow up when you're young?" She commented about being extremely ill as a child and asked if it was "normal" for children to have convulsions. "They used to tell me that I got convulsions all the time when I'd get sick. And I was wondering" - there was a slight pause, Louise flushed and looked down. "Well, when a child has convulsions does this do anything to them. Keep them from - well, make them different

some way? I mean so that they can't grow up as fast or something?" Louise commented that her parents didn't believe in doctors, were afraid of doctors and didnt' like her to take medicine. She thought that they really had helped her when she had hay fever. She said she didn't dare tell her mother if she went to a doctor and he gave her medicine because her mother was afraid sulfa "or any kind of medicine just about would kill me!"

107. Louise expressed concern about being "sort of alone and lonely" living by herself. She sat quietly for several minutes, then said, "I think I'll cal Lucy and see if I can practice on the team. I used to play softball with them. I was pitcher on the senior team first and then on the junior team, but I had to quit. Mother thought it was too late for me to be out, and then I got hurt and she wouldn't let me play anymore; but now that I'm living here -," there was a pause and she looked down. "Well, now I can if I want to. And I don't see anything wrong with it." She looked at the nurse directly as she said this, then abruptly dropped her head and looked at the floor. When the nurse said this sounded as if it might be fun, Louise looked up, nodded, smiled and said, "I'd sure like to try it again, even if Mother wouldn't approve."

108. The B. family lived in a small apartment in a flat-roofed, one-level, five unit, green stucco building. All of the units faced the street and opened on to a cement porch. In front of the porch was a waist high concrete partition. Six square pillars supported the front of a roof which extended over the porch. The building was dirty and the paint was chipped. The front yard was partially covered with lawn, and there were bits of paper and old newspapers scattered around. There was a dirty, electric, wringer-type washer in front of the B. apartment. The front porch was dirty and there were small piles of dry leaves under the washer and near the B's front door. (This visit occurred in March.) The units opened to a dirt yard in the rear, with a few shrubs and plants next to the building and a long clothes line behind it.

109. The building in which Betty lived was surrounded by vacant lots. The nearest house was a block away, and there was an industrial plant two blocks away. Each of the apartments in the building were about the same size. Mexican families, each with four or five small children, were occupying two of the units. There were seven children in the family living next to Betty, and

the mother of this family was pregnant.

110. The front door and screen were closed when the nurse arrived. There were sounds of footsteps and voices inside the house. A young girl opened the door about five inches and peeked out. Another girl was standing behind her, peeking around her. The nurse asked if Mrs. B. was at home and the child replied, "No." Nurse: "Do you know when she will be home?" Child: "Uh, I - I don't know." Nurse: "Is she at work?" Child: "I guess so." The other child said nothing. The child took a note which the nurse wrote, unlocking the screen door and opening it just wide enough to reach out for the note. She then closed and locked the screen and closed the door.

111. Betty had just told the nurse about her feelings of guilt and confusion about her relationship with J., a married man, and she said, "I went to Confession - I thought it would - might help -." There was a long pause, then, "But - there was - Father just told me to stop and - (slight pause) - there was nothing except more -- I didn't even do the Penance. And I can't go back. It's the first time I've been for months and I hoped - but -." There was a long pause and then she changed the subject.

112. Betty was waiting on the front porch when the nurse arrived, and walked rapidly toward her as she got out of the car. She asked if they might go somewhere else to talk. The nurse suggested riding, and Betty said, "Fine." She told the nurse briefly about her previous illness and her fear of becoming ill again. "I have to talk to someone or else I can't stand it. I'll be seeing the Doctor again next week, but I just can't wait that long because - well - I can't sleep or eat. I've been losing weight and I'm really frightened." "I'd rather die than be sick like I was again."

113. Betty was told that she could obtain medication (such as Thorazine) at the Emergency Unit at the County Hospital. She immediately shook her head several times and said, "No. I won't go down there. I can't -" She stopped abruptly and said nothing more for two or three minutes.

114. Betty asked about the possibility of obtaining Thorazine or a similar type of medication because she felt "so confused" and was unable to think or sleep. "I feel

so mixed up about everything - how it happened and all." She said she had known "this man" for a long time, but had "ignored him" until a few weeks after the death of her grandmother. "I feel like I have to so something about the situation now because I'm afraid that - I don't want to become ill again."

115. Betty met the nurse in front of her parents' home and asked if they could go "away" to talk. She said that she could not talk about things in front of her parents.

116. Betty started talking about John shortly after the nurse's arrival. The conversation was interrupted for a few minutes by Jean, her oldest daughter, but Betty immediately returned to the subject when Jean left.

117. Jean, the oldest daughter, entered the house and went into the bathroom, locking the door. Betty watched her, then said, "She spends a lot of time in the bathroom with the door locked. Sometimes I wonder - ." Her voice trailed off. Later she said, "The children haven't asked any questions about sex or - growing up - or anything, not for a long time. It sort of worries me. Jean and Shirley are getting close to -," There was a pause, then, "They should know about menstruation soon, but I don't know if I should just bring up the subject, or wait for them to ask, or what." There was a pause of 30 seconds. "I don't want them to find out the way I did - or feel the same way about it. You know, it was always - it sort of seemed dirty and I didn't know what was happening. I couldn't ever ask anyone. It - ," she paused 45 seconds, "I don't want it that way for the girls." She quickly accepted the nurse's offer for some material which would help her explain maturation to the girls.

118. Betty called Shirley, "Come in and put on a sweater." Shirley came to the door and said, "It's not cold out there." Betty: "Shirley, come in and put on a sweater, or else come in the house and stay." Her words were sharp. Shirley: "Why?" Betty spoke quickly, her voice harsh, "Never mind why. Because <u>I</u> said so, that's why. Come in and do it <u>right</u> now." Her voice became louder as she spoke. There was a silence of 1½ to 2 minutes, then Shirley said, "Well, I don't see why. It isn't cold out there." She was speaking softly. She came into the house, went into the bedroom, and returned with a sweater. Later Betty went to the door with the nurse. She stood there a short time, laughed and said, "You know it really isn't cold out there. It looks colder than it is. Maybe she didn't need the sweater."

119. Betty and the nurse were in the front room, talking. Jean came into the room, went over to her mother and whispered in her ear. Betty said, "What? I couldn't hear you." Jean looked at the nurse, leaned closer to Betty, and whispered more loudly. Betty again said she couldn't hear, and Jean sighed, then whispered again, putting her hand in front of her mouth and Betty's ear as she did so. Betty looked at her and said: "It doesn't matter. Just change your clothes. Wear your blue sweater if you want." Jean again looked at the nurse, looked down at the floor, and then left the room.

120. Betty said that she was sending the children to a Catholic school. "It's expensive, but I think it's worth it. That's the reason I'm working, so they can. I feel it's very important for them to have this."

121. Betty said that she had gone to Church very frequently before becoming "involved" with J. "I used to go in a lot after work, too. You know, just to go." She said that although she had had some difficulty with her feelings about religion when she was ill before, she felt that she had "worked this out," and "I really got a lot of support and strength from it. And I think it's very important for the children to have this - to get a good foundation. I think it will really help them later."

122. The apartment has a medium-sized living room. On one wall was a picture of Christ and a cross, and on another was a small mirror. A red, modern, armless davenport was on the side of the room, and in front of this was an oblong coffee table with a crocheted doily and an ash tray on it. In one corner, a door opened in to the kitchen. Near the door was a gas stove. Across from the davenport was a television set with a 17 inch screen on a swivel TV stand. Next to this was a closed door leading in to the bathroom. There was a small window on either side of the front door. Under one window was a chair which matched the davenport. The floor was almost entirely covered by a dull-covered rug. The floor and walls were dirty, and the tops of the television and coffee table were dusty. There was a door next to the davenport leading to a bedroom which was somewhat cluttered. The floor of this room was dirty. A bedroom next to this was not visible from the front room. There were dirty dishes on the kitchen sink and the linoleum in the kitchen was dirty and unswept. In the kitchen were a large refrigerator, a kitchen set with a table and four chairs, and an electric stove.

123. Jean ran into the house, crying, and said that a neighbor child had pushed her down and was teasing Jimmy. Betty said, "Stay away from them. I've told you to stay away from those children. Just don't go near them." Her voice was deep, her words short and clipped. She turned to the nurse as Jean left the house.

124. Betty said, "I don't like the children to play with those others. Some of the things they do - well, I just don't think it's very good for them to be together. I'll really be glad when we can move and get away from here. The other children don't mind at all. They're out on the street until all hours, and now my children are beginning to think they can do the same things."

125. There was an extension cord plugged into a light socket on Betty's front porch, and leading from the neighbor's window. Betty said that she was "real upset with my neighbors in the next apartment because the man told me when he first moved in that he just hadn't had his meter connected yet, but he would right away. He wanted to know if he could just use my porch outlet for a few days. I thought it would be all right." There was a few seconds pause. "A few days! He never has had his meter connected, and I've been pay his light bill too. I just can't afford it. I've asked him about it and he said he would pay me, but he hasn't. I called the light company, but they said they would not connect his meter until he paid a back light bill." She paused again, briefly. "I just can't leave them without any lights, so I guess I'm stuck."

126. Betty was waiting at the screen door and opened it as the nurse walked on to the porch. She invited the nurse to enter and sit on the couch. She then went into the kitchen and returned with a package of cigarettes and a book of matches, placed them on the coffee table and sat on the couch, about three feet from the nurse and partially facing her.

127. Betty sat silently for about three minutes after the nurse arrived. There were tears in her eyes and she looked at the floor. She then started talking about J., the married man with whom she was "involved."

128. Jean came home from school and went into the bathroom. Betty watched her, then said, "Jean is doing better at school this year, although it's hard for her - harder than Shirley. And she really likes her Sister (teacher).

She's decided she wants to be a Nun when she grows up. And she wants to go to Scotland to be a Nun." She paused for a minute, then added, "That's what I had been thinking about doing. When the children were grown, I wanted to enter a convent. It seemed like it would be ideal." She looked down. Tears came into her eyes. "But of course that's out of the question now. I couldn't -". She stopped abruptly, paused, then changed the subject.

129. Shirley came into the house and asked Betty if she might go with a neighbor child to the bowling alley. Betty replied, "No. It's dark." As she spoke, her voice became harsh and deep and the words were clipped. Shirley: "Please, why can't I go?" Betty: "No! It's dark out. You cannot go." Shirley: "Oh, please let me go." Betty: "No!" Her voice was loud. Shirley left the house. In two minutes she returned, went to the bedroom and came out wearing a jacket. She went to Betty and whispered in her ear. Betty said, "No, I told you, you can't go. It's dark outside." Shirley: "Well, why can't I? She's only going over to make a phone call. We'll be right back." Betty: "No!" Shirley: "Well, why can't I?" Betty: "Don't ask me why. Just because I said so." Shirley went out, slamming the screen door as she left.

130. It was about 8:00 P.M. The children were playing in the front yard. Jimmy, the 7 year old boy, came to the front door and asked if he could come in. Betty laughed slightly and said, "No, you're going to have to stay out there until tomorrow." Jimmy did not reply, but turned away from the door. Betty said, "Now he probably believes me. He'll be telling me for the next three days that he can't come in the house. He'll probably go to the neighbors and tell them he can't come in the house - that his mother won't let him." She was smiling as she said this. She called to Jimmy and told him to come in. He said: "I have to stay out here all night." Betty: "You really don't. You can come in any time." Jimmy did not reply. In three minutes he came into the house and got a jacket, saying, "I'm getting my jacket so I won't be cold when I sleep out there tonight." Betty: "Now Jimmy, you don't have to stay out there tonight." Jimmy: "Yes, I do. You told me I do." He put the jacket down and went outside.

131. After Betty told Shirley several times that she could not go to the bowling alley with the neighbor, Shirley came into the house and went into the bedroom. There was a squeaking sound from the bedroom, and Betty said, "She's gone to bed. This is another way to get me to let her go." In five minutes, Shirley went outside again.

132. Jean came into the house and asked if Shirley was going to the bowling alley. Betty said, "No, she isn't. And don't ask me." Jean: "Why can't we go?" Betty said, her voice loud and her words harsh and clipped, "No! It's dark now. You are to stay right here!" Jean looked at the floor, said, "Oh --," went into the bathroom, closed the door, locked it and turned on the light. Betty looked at the door. "I was expecting that. She's the only girl who can spend hours in the bathroom with the door locked. It must be the lock."

133. Shirley entered the house carrying a sack of groceries, put it on the kitchen table and started taking the things out of the sack. She asked Betty, "Can I start fixing some spaghetti?" Betty: "No. I'll fix dinner in a few minutes." She (Betty) then said to the nurse: "Shirley is able to do quite a few things, like go to the store and cook a few things. She comes back from the store with the things I wanted. Jean really likes to try, but - well, she doesn't remember as well. Even though she's older somehow, she just doesn't seem to be able to do things as well as Shirley. And she's so much smaller really. I think Shirley will even mature before Jean and that will really be hard for her. It's hard for her to have Shirley able to do more, so I try to let her do things when I can be here to help her." She paused briefly. "But I can trust Shirley to get things and do things better than Jean.

134. Betty was talking about J. (her married "friend") and said, "I feel like I've got to do something about this and it's all I can think about." She paused. "When I get sick, I do things - - I think of the nastiest things to do. My thoughts and ideas get worse and worse when I get sick. I can really be mean when I'm like this." She was smiling, but her eyes were serious. "I want to ask you what you would say or - well, what you would think about - . (Slight pause.) I have decided that if - John said he would pick me up after work on Friday and I have decided that when he does - afterward I'm going to call his wife and - oh, I won't tell her I'm the other woman or anything, but -- well, I keep thinking about this and I feel that maybe it's for her - would be better for her to know." "I don't really want to hurt her and I am afraid it might upset her, but I feel that I have to do something. I want to call her and tell her I've seen her husband pick up another woman several times at the same place, and - well, then see what would happen. And - well, I guess what I really want is to know if you approve of this idea."

135. Betty said that she was not sleeping at night, and that she was almost out of medication. "I meant to get the prescription refilled today, but I was just too tired when I got home. I have one left for tonight and I'll get some more tomorrow. You know, that really does help when I take it."

136. Betty told Shirley to stay in the house, and suggested she read "or something." Shirley sat on the floor of the front room, playing with a toy gun. The gun made a loud sound as she shot it. She did this several times and Betty said, "Shirley, why don't you go in the kitchen and read or something else." Shirley continued to sit there for several minutes, shooting the toy gun several times. Each time, Betty looked at her, but did not say anything. Then Shirley stood up and went into the kitchen.

137. Betty looked at a toy gun and said, "That's Jimmy's gun. And when he shoots it the whole house is dead. In fact, he's always killing people. I like that about my son. He's always shooting someone. He either has a real good imagination or he's real sick, that boy."

138. Betty started talking about J. (her male 'friend') after the children left the house. "He picks me up after work every day. I don't know how he does it, because he never works. He really hates work, that man. He told me he's going to teach me how to fly a plane, but he's been saying this for a long time."

139. Betty and the nurse were seated on the couch. Jean came into the house, looked at the nurse, said, "Oh," and started to go outside again. Betty told her to stay right in front of the house. Jean looked at her briefly, did not speak, and left.

140. Shirley was reading by the open door of the kitchen. Her hair was wet and she had a towel wrapped around it. Betty commented about Shirley's hair which is long and has some natural wave in it. Shirley stood, removed the towel and put it on top of the kitchen stove, then again sat down and started to read. Betty turned to look at her, then said, "Shirley, put the towel on your head-" (Slight pause) -"please." Shirley looked at her but did not move. Betty again asked her to do this and Shirley asked, "Why?" Betty said, "Put it on. The whole back of your blouse will be wet. Please, Shirley." Shirley read another line or two,

moving a card along under the words. She brushed over the pages of the book very slowly, closed the book leaving the card as a marker, put the book down slowly, stood and picked up the towel. She held it in her hand and walked around the kitchen for a moment. During this time Betty was watching her, but did not say anything. Shirley took the towel, which was knotted, and held it up to her head. She untied the knot and slowly put the towel around her head again, tying it in place. She then walked through the front room to the front door, and stood by it looking out.

141. Betty said that she had suddenly become aware that whenever she started to pull away from J., he used little things to bring him closer to her. She just realized that it had happened several times. He told her that he was upset because she had "seemed so cool" to him on Tuesday. She had had Jimmy with her at the time. She said, "I didn't really feel that I was cool to him. I felt like I wanted to - and this is real foolish too - but I felt like I wanted to keep my child away from this - away from him." "Somehow I feel that I don't want my children to get near him, to have them even see him." She was looking down as she said this, and her body pulled back slightly as she spoke. "He didn't receive the contracts that he expected and he was upset about this - that his bids had not been accepted. He said he was real upset because I was so cool when he made the bid, and then they didn't -" (There was a long pause.) "And then I felt guilty about this, too, as if it was because -" She stopped abruptly. "I guess I have so many guilts right now that I just take everything this way."

142. Betty was standing in the doorway when the nurse arrived. She smiled and held open the screen door. The nurse sat near the north end of the couch and Betty sat at the south end with one arm resting on the back of the couch, her legs crossed and resting on the couch. There was a silence of about one minute, then Betty commented that she was "tired, just real tired - and I'm so tired of being tired all of the time."

143. Shirley came into the house as Betty and the nurse were talking. Her hair was wet and she had a towel wrapped around it. Betty told her that she "should stay in the house now." Shirley said, "Well, why?" Betty pointed to herself and said, "Don't ask why. I told you to. Just stay in the house." Her words were clipped, her voice deep and harsh as she spoke. Shirley looked at her for about 30 seconds, then turned

and went into the kitchen.

144. Betty said she had become "very upset" at work. She had forgotten something for one customer and had to be asked for it, and had taken another customer two bowls of soup (one after the other) and two salads, forgetting that she had taken the first one. The customer had told her about it and she said she became very angry at him and kept insisting that this hadn't happened. "But I knew he must have been right. It upset me a lot. Usually I don't have any trouble at all. It really frightened me when I realized I'd forgotten so easily. It was so hard for me to think about work and what I was doing. It's all just sort of automatic, and I really am not sure what I should be doing part of the time - or it seems like I'm not. It frightens me that I might be getting mentally sick again."

145. Betty showed the nurse a pin that Jean had found on the street and brought home, saying that Jean saved everything she had or found. "I don't understand it - why she does this. And she gets so upset if I throw anything away. I don't like to hurt or upset her, so I just have to wait until she isn't looking and then throw it out a little at a time. She's the only child I know who collects everything there is to collect." She was smiling as she said this and laughed shortly as she added, "I don't really understand why - either she's going to be a garbage collector when she grows up or she's real sick, that girl."

146. Betty watched Jean go outside, and said, "Well, I don't know what she had on, but it was purple and green. The clothes that girl wears! Sometimes I wonder if she'll ever get interested in the way she looks. She just - well - I hope she changes. There's something - Shirley isn't like that, but Jean just doesn't seem to care. She has asked for spool heels and nylons for Easter, and she can't have the nylons yet - she's only eleven, but I do think the spool heels will be all right. So maybe she is getting more interested." The nurse discussed a little about differences in children, their rate of maturation and interests, etc. Betty just nodded and then changed the subject.

147. Jean came into the house. Betty looked at her and said, "Jean, take my sweater off, right now!" Her words were abrupt and firm. Jean did not reply. Betty said, "I'll give you just three seconds." Jean: "Well, what am I going to wear?" Betty: "I don't care what

you wear, but take off my sweater right now." Jean went into the bedroom, and Shirley followed her. In one minute Betty said, "Has Jean taken off my sweater?" Shirley replied, "No, she hasn't." Betty: "I told her I'd give her three seconds." There was a short silence: Jean said, "Where's mine like it?" Betty: "I don't know." Jean went out to the back porch and returned carrying a turquoise sweater in her hand. She went into the bedroom. in a short time she came out wearing a cardigan sweater. Betty watched her leave the house, then said, "This is one thing I like about my kids. They <u>always</u> obey me (smiling as she said this) and they just love to wear my clothes. I can't keep anything for myself. One day I had all my sweaters cleaned and pressed and when I came home they each had one of them on, with dirt and mud all over them. They really looked lovely."

148. Betty was talking about work and said, "Sometimes I get so tired and sometimes I feel like I just have to leave - can't stay there any longer. But somehow I do. It's so hard, but - well, it's about the only thing I can do with those hours and everything. And I feel that it's so important to be home with the children - to be there when they are. And it's really the only kind of work I can do." There was a long pause and then she changed the subject.

149. Betty was talking about J. (her male friend) visiting her at work and she said, "Sometimes I wonder about him. He always comes into the cafe where I'm working. I've worked at three different places, and he always finds out where I am and then that's where he goes. I've tried so hard not to let anyone know about us - sometimes I'm even quite cold toward him in the cafe so that no one will suspect. But then today he came in while I was having lunch and he sat down with me and ate. I should think they'd wonder when he sits down with me like that. I just don't really associate with anyone at work. I never have and this is so different than my usual behavior that I was really afraid someone would suspect."

150. Jimmy came into the house, leading a large black dog. Betty said, "Oh, he's brought Blackie home with him again. This is all we need, another dog. You know how many pups our dog had? <u>Our</u> dog I call it, only it's not ours. I don't know what we're going to do with the thing. Seven pups! Now we've got eight dogs and Jimmy brings Blackie home." "Blackie was given to the

children, but we only had him a few days then we gave him to Mother." Each time she spoke of the dogs her eyes became very serious, and at one time tears formed on the lower lids. She sometimes smiled with her lips at the same time. "I've tried to give the pups away, but I can't do that. I'd like to lose them. I've just got to call the Humane Society tomorrow to come and get them. The children will just die when I do, but I've got to get rid of them."

151. Betty said she had difficulty getting her prescription for Thorazine refilled and had been very depressed and upset until this had been done. "The pill really helped and I felt much better when I was taking it - but I hope that I won't have to keep taking it all my life."

152. Leon, the three year old child whom Betty was tending, climbed up on the couch beside her. He sat close beside her and rested his head against her body. Betty put her arm around him, hugged him gently and then turned back toward the nurse. In a few minutes, Leon climbed down from the couch and went into the kitchen, climbing up on a chair beside the open kitchen door. In ten minutes, Leon again climbed on to the couch beside Betty. She put her arm around him, ran her fingers through his hair and smiled at him, spoke to him a little, then turned back to the nurse. In twenty minutes she looked down at Leon, smiled , and said, "Oh, he's asleep." She gently lifted Leon into her arms, carried him into the bedroom. He opened his eyes and she said, "Let's go in an sleep on my bed." She then said softly, "Now you can have a good nap. I'll cover you up a bit." She returned to the front room. Leon slept until a baby sitter came to get him.

153. As Shirley took a malt out of the freezer, Betty said, "Everything gets frozen around here. I take them over and buy them a malt, they eat a third of it and the rest of it goes in the freezer for three days. It's a lot more economical that way but mine are the only kids I know that do this. They save it and save it. I can't understand it. It just seems so different." She paused, then said that Jean saved everything. "I don't know what I'm going to do about that girl. I can't understand it. She saves everything she gets. She collects and collects. Anything that anybody throws away, if she thinks it looks good she brings it home and puts it away somewhere. Every paper she's ever made in school she's brought home and stored in there. She's got boxes full of stuff. And I can't hurt her feelings, but there just isn't room for everything . . . She really gets upset if she knows I'm throwing anything away. She

just cries and cries. I asked her one time what she saved it for and she said she didn't know, she just did and that was all. . . . Every once in a while I throw away a box that isn't important when she isn't around."

154. There were sounds of a child crying as the nurse approached the house. Betty was speaking loudly. Her voice was strident, the words were short and sharp. She was standing in the kitchen door facing the bedroom. The crying child said something and Betty replied, enunciating her words very distinctly. "Get your clothes changed now, Jean." Betty turned and invited the nurse in, then sat on the couch near her. Her face was serious. There were lines around and deep circles under her eyes. The sound of crying continued and Betty said, "Jean's really had a bad day today. She misunderstood what I told her. I told her on Saturday that either Monday or Tuesday we'd go to town and buy their Easter shoes and then today (Monday) when Leon was dropped off she really got upset. His mother had to work and I told her I'd take care of him for a while. Jean thought we were going to town today and I told her it would have to be Tuesday now. She's been crying ever since." It was about thirty minutes before Jean left the bedroom.

155. Betty and the nurse were in the front room when a red and white station wagon stopped in front of the house. Betty said, "Oh, there's my mother," and stopped abruptly. A woman started to get out of the station wagon, looked toward the nurse's car, spoke to a neighbor who was in the front yard, got back into the car, waited about five minutes, then drove away.

156. Jimmy had brought the dog, Blackie, home from his grandmother's home, and then had left him in the front room "so he won't hurt the pups." The dog started to yelp and tried to get out. Betty opened the front door for him. Soon Jean came in through the front door leading the dog and said, "You've got to keep this dog in the house. That mother dog will kill him. She really will. She's got those pups out there and you know how a mother dog is about her pups and she'll kill him if you let him out." Betty did not say anything and Jean went outside. Soon the dog started scratching the door and yelping. Betty again opened the door. He was out about two minutes and Jean brought him back, saying, "You've got to keep him in or he'll be killed." The incident was repeated when Betty again let him out, so Betty then told Jean she would have to take him home

if he couldn't be outside. Jean said, "I didn't bring him over." Betty: "You've got to take him home. Take Jimmy's bike." Jean said, "I didn't bring the dog over here. Why should I have to take him back?" Betty repeated, "You've got to take the dog back to Grandma's house. Ride Jimmy's bike and leave the bike there. Do it right now!" Her words were forceful, her voice harsh. Jean went out of the house, saying, "Well, if this dog gets killed, it's not my fault. He won't go with me. He's not going to follow me. I don't know how I'm going to get him to. It's not my fault if he gets killed!" She slammed the screen door, got on the bike, called once to Blackie and rode away on the bike.

157. Betty said, in regard to some friends, "I don't understand how they can live the way they do. I don't think I could stand this. They never see each other." There was a pause of about thirty seconds, then she added, "Of course this is one thing about it - it's one way to be married and stay together. If you don't see each other you can't fight or argue ever, can you? And maybe it's the best way to make a marriage work. Sometimes I wonder how - I don't know how people do stay together sometimes." She was smiling as she said this.

158. When Jimmy came into the house his shoes were untied. Betty said, "Jimmy, come and let me tie your shoes." Jimmy went over to her, put his foot on her lap and she tied his shoe. He started to walk away and she said, "Let me do the other one." He put his other foot up and she tied that shoe. He then went into the bedroom, and Betty said, "Seven years old and I still have to tie his shoes. Some day he's going to have to learn how."

159. Jimmy has a speech defect and some of his words are difficult to understand. Betty said that he had a year of speech training in the public schools and that she was told that his problem was one of immature speech and that he would probably outgrow it after a while. She felt that his speech was improving, but that at times she was still concerned about it because he had such difficulty with some letters and words.

160. Betty said that J. had offered to help her financially, but that she had told him she didn't want and couldn't accept that. She told the nurse that she preferred to manage things for herself and the children and that she

"couldn't accept any money from him - it just -" and she stopped suddenly and changed the subject.

161. Betty showed the clothes she had purchased for the children for Easter. Each of the girls had a nylon dress, a full half-slip, new shoes and flowered headpieces. She had bought Jimmy slacks and a jacket, a "dress" shirt, a bow tie, and shoes. Jimmy had not been with her when she bought the clothes and she said, "Oh, I hope they're the right size. I just couldn't remember for sure what size to get." Jimmy came in, tried them on and they did fit.

162. Betty said that she had been at the light company, trying to "straigten things out." They had turned off her lights because the man next door was using them too, and they said that this was illegal and unsafe." She said that she had asked the man several times for the money for the light bill, "But he just calls his wife who's expecting another baby and all of their children and lines them up in front of me and says, 'This is my wife and these are my children,' as if he didn't unerstand or something. And then I don't know what to do. I can't leave that poor woman and those six children without any lights. And he says that if he pays me he can't buy food for them, and then I just feel guilty for saying anything." She paused for a moment. "But then we have to eat too, and I can't afford to be feeding his family. I - well - it's really a mess."

163. Betty mentioned that John had made "some big plans" for the week and said, "This bothers me. It really bothers me. This is a real important week for our Church and it's important for the children because of school and everything. The children participate and I feel like if they are, I need to participate too. It's important that they should see me - that I should at least make an effort and that they should see me doing these things. I feel that if something is going to be important to them and if I want it to be important - and I do - then I should be there taking part so that they can see me do this. This really seems like the right thing to do even if it is hard, because I think children should feel that their parents - well, that they believe and practice these things too. And now J. has things that he wants me to do with him, and I just don't know -" There was a pause, and then she said, "I really want to do this. And then, too, I hoped that if I did - well, that maybe some of the feeling would come back. The belief, you know, and -

well, that maybe I'd start finding an answer."

164. Shirley came in to the kitchen and opened the refrigerator door. Betty looked at her and said, "You won't find anything new in there. You just looked five minutes ago." She turned to the nurse and said, "Every five minutes they expect it to change and it never does. They keep expecting it to. They're the only children I know who spend half their time looking in the refrigerator, expecting something new. I keep telling them there isn't anything, but they have to look anyway."

165. After leaving work, Betty said, "I have to make a stop - at Sears. I owe them some money and I've been telling them I'd be in to pay it, but I just haven't. They'll be after me pretty soon, wondering why I couldn't just walk these few blocks to pay it. It's not much but it's hard to get the money. There are so many places it's needed, and I never seem to have enough." (At Sears, Betty paid $4 on an account.)

166. Jimmy came into the house with Blackie, the D's dog. Betty said, "Oh, not again." Jimmy walked past, saying. "Come on, Blackie." He led the dog into the bedroom. For several minutes there were sounds of his voice from the bedroom. Betty said, "He's talking to the dog again. He has to feed it and sleep with it. My kid's the only boy I know that sleeps with a dog and talks to him, even reads to him. I really don't think the dog understands, but Jimmy doesn't like being told that." She smiled as she said this, but there were tears in her eyes. "I don't know about that boy. He really does - he really spends a lot of time talking to that dog."

167. Betty told Jean and Shirley to stay in the house. They looked at her briefly, then went out the front door. In a few minutes they returned, went to the refrigerator and opened it. Betty told them not to eat anything as dinner was in the oven and would be ready in a few minutes. Shirley took out a bunch of bananas and both she and Jean took one, then went out through the back door. Betty watched them, then said, "There's one thing I notice and that is that when I feel worse, the children do more - they obey me less. I don't like this. I don't like having this effect on my kids. It really bothers me that I'm doing this. I feel that I must have discipline and they can always seem to tell when I'm not feeling good and they just don't pay any attention to me. Both last Sunday and

yesterday was really bad. I was feeling terrible and they just didn't even listen or do a thing I told them to do. They just didn't pay any attention to me at all. This really bothers me. I don't think that this is good. It's wrong. It's real wrong for me to have this kind of an effect on my children."

168. Betty said, with tears in her eyes, "I could hardly stay in town today. It was - all those people. We looked in several stores and - " There was a pause of several seconds. "I finally said we'd have to take what was right there. I just couldn't stay any longer. Even waiting for a bus - I just wanted to get away - not be around anyone at all. I don't even know if I got the right size for Jimmy. He wasn't with me and I couldn't remember his size. I hope it fits him. I couldn't stand to go back again. It's awful not to even be able to remember your own child's size."

169. Betty was at the cafe sitting at a table by herself. She was just finishing her lunch and was smoking a cigarette. The nurse sat down across from her. Twice another waitress came up and spoke to Betty. She smiled at her and answered with a "Yes" or "No", accompanied by a nod or shake of the head. One time the waitress chatted for about two minutes. Betty looked at her and listened, but gave no verbal response other than the yes or no. The waitress left to wait on a customer. Betty turned back to the nurse and started to talk.

170. Jean was in her mother's bedroom. Jean was dropping marbles one at a time into a cardboard container. Betty said, "Jean collects marbles. She has hundreds of them, and she just loves to count them - one at a time. She spends hours just doing that."

171. While talking about John, Betty said, "I seem to be at sort of an emotional standstill. I just don't seem to have any kind of feelings - no feelings at all. And this is real strange. It happened before, around Christmas time. I told him that I was so full of guilt that there seemed to be a real wall between the children and myself, and this was bad, especially at Christmas time. I felt like maybe if I didn't see him for a couple of weeks - that if for a period of time there was nothing doing between us - that this might help. So I told him I felt that I should spend this time with my children and that it would be better if we didn't see each other for a couple of weeks. And this was real funny too, because then he told me he was going

to be out of town. I really chose a good time to do this and it seemed to work out." There was a pause, then she said, "But he was only supposed to be gone for two or three days and he was gone for a full two weeks. He just disappeared and nobody knew where he was. People thought he'd crashed in the mountains or something. And I kept watching and waiting for some kind of news and then I just didn't feel anything any more. And even when I saw him the first time, I didn't feel anything."

172. Betty approached each new customer at the cafe almost immediately after their arrival. When waiting on a customer, she smiled, but said little, answering questions with quick, short answers, nodding when the customer gave an order and writing it immediately on the ticket. Twice she came over and stood by the counter where the nurse was seated and made a comment or two. Other than this, she was constantly busy. When the cook rang a bell to indicate that an order was ready, Betty went immediately to the service window, got the order and took it to the customer. Her movements were quick and efficient. Each place was immediately cleaned when the customer left. When two customers entered, she got a glass of water and a cup of coffee and took it directly to them without approaching them about the order first. These men thanked her and did not ask for anything else.

173. At about five minutes of two, Betty glanced at the clock and kept looking at it as she moved about the cafe. At 2:00 p.m. she removed her apron, picked up her purse and cigarettes and started toward the door without speaking to anyone. She left the cafe. Soon the cook ran out and called, "Betty". She turned back and said, "What do you want?" He told her he just wondered if she was leaving, and she said, "Yes. It's two o'clock and I always leave at two." He nodded, and she turned and walked away.

174. Betty said that she had stopped by the Church on her way home from work. "It might be hard for anyone to understand - (slight pause) - but I used to feel so close to the Blessed Virgin - like there was a bond between us sort of. And almost every day I'd go in and light a candle - not to ask for anything, but just for Her. I haven't done that for a long time, but I did today." Paused 45 seconds. "But there was nothing - just nothing. And I felt - I felt like - I did so want for there to be something." There were tears in her eyes as she said this, and she looked down at the floor

for several minutes. She changed the subject.

175. Betty opened the front door immediately after the nurse knocked. She went into the kitchen, saying she would just be a minute. She stood by the stove, took a cigarette out of a package on the stove and turned the stove on to light it. She then returned to the front room and sat on the couch, about four feet from the nurse. Twice within about three or four minutes she moved slightly further away from the nurse. She was seated directly facing forward with one foot resting on the coffee table. After they had been talking about twenty minutes, Betty went into the kitchen. When she returned, she sat closer to the nurse, put her arm on the back of the couch, and sat facing the nurse with her knees bent and her legs resting on the couch. She remained in this position during the remainder of the visit.

176. Jean came into the front room where Betty and the nurse were talking. Jane suggested that she (Jean) go outside and play. Jean went into her mother's bedroom. There was the sound of objects being dropped one by one into an empty box. This continued for about two minutes, and then Betty said, "Jean, can't you do that more quietly?" Jean did not respond, but continued to drop the objects one at a time. Betty said, "Jean!" There was no response from Jean. Then there was the prolonged sound of a lot of small objects being poured from one container to another. Betty looked toward the bedroom, then at the nurse, and said, "That's what I like - the way they obey me. Really obedient children - that's what I've got." She changed the subject. The sound of the marbles continued.

177. A red and white station wagon stopped in front of the house. A woman got out of the car and walked toward the house. She opened the front door and came in without knocking. Betty said, "Oh, this is my mother, Mrs. D. -- and this is Miss H." Mrs. D. smiled and said, "Hello," in response to the nurse's greeting. She then asked Betty where the children were and said that Jimmy was bringing the dog home again. "And since he's your dog, why don't you keep him?" Betty laughed shortly, "He's not my dog - and I don't want him." She then asked if Mrs. D. would take care of the children for a little while the next day, and Mrs. D. did not answer directly. All during the conversation, Mrs. D. kept looking at the nurse, but did not speak to her directly again.

178. Betty said, "Oh, one thing - the puppies solved the

problem - you know, about telling them about menstruation and everything. She was so big and suddenly she was thin and there was no cut or anything and the children couldn't understand how the puppies got out of her stomach. They asked me about it just as I was getting ready for work in the morning, and I didn't have time then. But that evening I used the pamphlets you brought and told them about the egg and the uterus and the vagina, and then explained that the dog was somewhat the same way- the puppies had been born that way. And I think it was really all right - that they understood. And I felt good about doing it." She paused for a short time, then said, "They didn't ask about anything for so long that I wondered if I had done something so that they could not, but I guess they just weren't ready."

179. Betty commented that if she moved into her parent's home, "I'll pay Mother about the same as I'm paying here. I always have when I've lived with her. It won't -" There was a slight pause, and then, "In fact, it might be a little more. I - I haven't thought about that."

180. In talking about moving, Betty said that she felt she had to get a place near the Parochial school for the children. "I can't afford to pay bus transportation as well as the tuition. In fact, that almost costs more. The only way the children can do it is if we live close enough for them to walk. And I feel that it is very important for them to go to school there. I think they need that. It was hard for Jimmy, especially, to get used to the discipline, but there is so much good for them there, too. The Sisters and the Father - I just want them to have it."

181. Betty was waiting on a customer when the nurse and an observer entered. At two o'clock the nurse asked Betty if she would like to get a cup of coffee and join them at one of the tables. She looked at the clock, immediately took off her apron, obtained a cup and saucer, filled the cup with coffee and walked with the nurses over to the table. She sat with them and chatted about work and her fellow employees, answered questions and made comments in response to the remarks of the nurses. When she had finished her coffee, the nurse asked if she would like a ride. Betty quickly said, "Why, yes, I'd like to go over to Grand Central if you don't mind. I can look around over there until it's time to go to the doctor."

182. Betty's eyes were red and swollen and there were dark circles under them. She said that she had just been

notified that she would have to move in six days. She stated that she was angry because she had been told it would not be necessary for her to move until school was out. Suddenly a man had come and said they were going to turn off the lights and water on Sunday because they planned to tear the building down to make way for the new highway as soon as possible. Throughout the visit there were tears in Betty's eyes, her voice was low and her speech blocking. She sat silently for long periods of time. Several times she commented about being "very cold" and unable to get warm, saying that she felt "cold inside, all the way through."

183. Betty said that she had told J. the week before that she mustn't see him again, but that all day she had wanted to see him terribly. She had felt this desire to see him and had almost called him. Several times she felt as though she had to leave work - to get away from everyone and twice she had put her things down and had gotten ready to leave, then had stayed. She felt that she couldn't tolerate being around people at all when she felt this way.

184. Betty said she had never learned to swim. "I always did want to, but somehow I never learned. Maybe sometime ...." Her voice trailed off. The nurse suggested she might enjoy doing this. Betty looked at her, there was a brief silence, then Jane nodded and said, "Yes, I might."

185. During almost the entire visit Betty discussed the problem of moving and trying to find a place to live near the Parochial school so that the children could walk to and from school. She discussed moving in with her parents and the problems which might arise from this, her concern about storing her furniture if she had to move to her mother's house, etc. She said she had also had a "fight" with the man next door because she had to have the money for the light bill if she was going to move. He had told her he would pay her right away, "but he's been saying that for months now so I don't really expect it."

186. Betty mentioned J. only once and that was to say that she felt she had to see him, even though she had told him she couldn't see him again. "I don't really understand what the need is, but it's there. I almost called him today, and I kept wishing he would come in to the cafe. But of course he didn't."

187. Shirley came in and asked Betty if they would be able

to take swimming lessons during the summer. Betty said that was "quite a while away,"so that they would have to wait to see. Shirley said, "Please let us. We really want to. Please." Betty replied, "We'll see."

188. Betty said that she had been forced to move several times in the last three years. "None of the moves have been permanent and it really is hard. I have a feeling that there isn't any permanency anywhere. Once I thought we had a house we could stay in and we just got it all painted and fixed up and then they came and told us the highway had been changed and was going that way and we'd have to move again. I'm beginning to think the highway is following me." She laughed shortly, then became serious again. "I just wish - it would be so nice if - sometimes I have a feeling that we'll never be able to be settled - really settled, I mean."

189. Betty and a friend, Edith, were discussing the clothing their sons would need for First Communion. Edith commented that this was the first time any of her children had participated, but that she knew it was not the first time for Betty and so she had come to ask her about it. They talked about taking pictures, the things that needed to be done before the Communion, etc., with Betty explaining to Edith what the procedure was. During this time, Betty talked quite freely and there was no blocking of speech.

190. Betty said she had been unable to locate a place to live near the school and was afraid she would "have to move in with her mother." She said, "In some ways I think it might be good, really, and yet -" there was quite a long pause, and then she said, "I know - I can see that I became quite dependent on -" She stopped, looked down, then said, "I'm afraid I might - in fact, I think I already have - transferred some of this dependency to my mother and I'm afraid I might get back into it," "I was always too dependent on my mother, and while I was in therapy before I worked on it. I was dependent, even if I didn't love her. And she - well, she encouraged this. But I sort of got out of that, but now - I'm a little afraid I may get back into it again."

191. Betty said, "It worries me because since I've been feeling this way I really haven't been able to give the children anything. I feel like there's a real wall between us and it isn't good. It's wrong - real wrong - to have it this way. But I just can't do anything else. I feel it's there, but I can't do anything about it."

192. Edith commented that Betty had made the girls' dresses for their First Communion and had really put a "lot of time and fuss" into them. Betty smiled, leaned forward and said she had enjoyed preparing the girls. "I had difficulty with the collar of one and had to put it on about ten times before I realized I would have to cut it a little bit differently to fit the dress." As she talked about making the dresses and veils, her voice became a little bit higher, her words a little more rapid, she moved her body forward and her eyes and lips were smiling. She said she had really enjoyed making the outfits -" At that time I really enjoyed sewing."

193. Betty was talking about moving in with her mother. "I know I have a need. The need is there and I keep looking for it to be answered, but it never can be and I keep looking. I sometimes feel like - and this isn't wise either - but I'd like to be able to see him again (referring to J.) and yet, I don't think this would answer the need either. I keep wanting to find that the need can be answered, but I know that it really can't, not there. Any Mother can't fill this need. It's good, because when I'm with her she won't accept the way I feel - she won't accept my feelings at all and so I just have to keep moving and doing things."

194. Betty said, "When I was ill before I so wanted to have my mother accept - but she never could. And now with J., it's the very same way. He can't accept either. Everyone has to be strong for him, and I know how he'd react if I told him. Sometimes I just need to have him listen and understand, but he can't do that. He always starts talking about his problems instead."

195. Betty's brother was in front of the house asking a neighbor questions. His voice was teasing and the woman with whom he was talking was screaming at him. Betty said, "My brother has to come down here every day and tease Annie. Now that's a woman that's sick. She's real sick. This has been going on for years. About ten times a day she calls the police to report the children. For a while the police used to come down here, but they don't any more. She gets so angry and she threatens the children, chases them and screams at them. I try to get mine to leave her completely alone, but they can't even go near her yard without having her come out and tell them to go away. And that's a little hard when the houses are practically on top of each other.

196. The yards of most of the houses in the court in which Betty's parents live are neat and well kept. There are

lawns, trees and flowers around them. The homes are small and quite close together. There is a parochial (Catholic) school behind the D.'s yard, and a public school (elementary) behind the houses across the street. A river flows about a block away from the house. There are several Negro and Mexican families living in the vicinity.

197. Betty looked at Annie's house. "There really are some sick people down here. There's a man across the street who goes over to the school and exposes himself to the children. He's been reported to the police and they're just trying to catch him doing it. They say they can't do anything unless they catch him. And then the man next door - I feel so sorry for that family. Those children - some of them are grown and married and seem to be doing all right. But one of his daughters was pregnant when she was only 11 - and they think he's the father. And he's drunk all of the time. When he works, he spends all of his money for liquor. His wife finally left, but some of the children stayed with him for a while, and that was really a mess. And Tom - they live next to Annie, you know - he's got three cafes now and he goes at 4:00 a.m. and doesn't get home until 11:00 p.m. He's just going to kill himself and the children never see him. They have six children, but they don't even hardly know they have a father. It seems so strange that he'd be away so much when the children really need him so."

198. The children had gone to a movie, and Betty said that she lets them go almost every Saturday afternoon and gives them fifteen cents apiece to spend while they are there. "They know they can't have any allowance while we are living here, but I do think they should be able to go to a movie or something every week."

199. Betty said: "I went into the Church and lighted a candle. It's the first one I've lighted for months. And I prayed - I honestly and sincerely prayed - that something would go right. You know, to find a - a house, and then to - to have J. make a decision or help me to make one - All week I prayed, but -" there was a slight pause, "There was nothing. I - I felt nothing, and nothing has happened. And then I wondered. I really and truly wondered. And I just don't know." There was a long pause and then Jane changed the subject.

200. The building in which Betty was living was condemned for the building of the new highway. Betty was given a

final notice of a week in which to move. She moved into her parent's home.

201. Betty's parents live in a small white frame house at the end of a deadend court. There is a neat lawn around the house, with trees, flowers and shrubs planted around the house. Three steps lead on to the front porch which is clean. A small front room contained a davenport, a matching and two other (one overstuffed) chairs, a telephone stand, and end table, a TV tray with a doily and ash tray on it, a television on a swivel table, a knick-knack stand with three shelves covered with miniature ceramin animals, and a cabinet. The floor was carpeted, and there were two large scatter rugs, one in the center of the floor and the other in front of the kitchen door. A coffee table stood in front of the davenport and had a doily and vase of artificial flowers on it. On top of the television set were two framed photographs, wedding pictures of each of Betty's brothers. (There were no visible pictures of Betty or her sister). An open door revealed a small bedroom which was clean and tidy, but full of furniture and things. Another door opened into a good-sized kitchen. There were doors to another bedroom (which Betty said she and the children were using), a bathroom, and a back porch in the kitchen.

202. Mrs. D. came into the room, looked into her bedroom (where the bed was unmade), turned to Betty and said, "Couldn't you even make my bed?" Betty replied, "He (Father) didn't get out of it until noon - just before Miss H. came." Mrs. D. had already walked out of the room. Betty looked at the nurse and said, "I guess I should have had it made. Now she'll really be upset." She then turned and looked toward the kitchen, and did not say anything for about five minutes.

203. Betty said, "John said he doesn't care at all about money - that this isn't important to him. He says it all the time. But I can't understand that." There was a pause. "I-well, don't most people want to have - or am I just different? I - well, I'd like to have enough for things we need. It seems like there just isn't ever any and the children need things all the time. I worry about it because I don't have enough."

204. Betty stated, "When Mother learned that I was going to have to move in with her, she went to Las Vegas suddenly for a couple of days. She just couldn't take to the idea. She'd been ignoring the problem until the last minute, and then she just had to leave." She had tears in hereyes as she said this.

205. Betty said, "I'm going to baby sit tonight with my sister's children. They go over to the church to play Bingo. That's their way of donating." She laughed and said, "And Mother goes with them. She just loves that game. She wouldn't miss Bingo on Saturday night for anything." Later in the visit Betty commented that her parents go to Las Vegas once a month, sometimes to Elko and sometimes to Ely. "Mother just loves that trip. I think my father just gets stinko, but Mother loves the trip and to play at the tables a little."

206. Mr. D., Betty's father, was seated on the chair next to the kitchen door. He leaned forward and said in a soft voice, "What do you think about Betty? What's -" there was a slight pause, "What are you supposed to be doing for her? We don't know - actually, I think that all that's wrong with her is that she is too dependent on her mother."

207. Mr. D., Betty's father, commented that he was "under the weather," that he was sick with the flu or something and had been trying to "drown it," but that this really hadn't helped. "When I'm sick, I can't tell whether I've been drinking anything or not." His face was flushed, his voice husky, and he had a deep cough. He said he had had pneumonia a few months before and was afraid of getting it again. "I thought a little alcohol would make me feel better, but I think I only really feel worse."

208. Betty came into the room and Mr. D. left the house.

209. Mr. D. was seated on the end of the couch, smoking a cigarette and looking straight ahead. The television was on and a negro woman came on to the screen. Mr. D. said, "If there's anything I can't stand, it's Mexicans and Negroes. And it seems like they're everywhere I go now." "There didn't used to be any around here, but now they're all over the place. Negroes living down on the corner - just all over." He was silent as Betty came into the room.

210. Mrs. D., Betty's mother, was seated on the end of the davenport and one of the dogs went over to her and jumped up on her lap. She hugged and petted the dog for several minutes, commenting that this dog was very lovable, liked a lot of attention and couldn't stand to be punished. "Every time I punish her, she has to make up. She really gets her feelings hurt until I hug her and let her know it's all right."

211. Betty commented: "My mother is able to give the dogs

a lot more affection than she could any of us. And with the children - she can give affection to Jimmy, but not to the girls. I really notice that. And she did it with my brothers too. But I think she even does it more with the dogs. They're even more than like children to her."

212. Betty's parents were in the back yard and Betty said to the nurse, "I don't know why or how they've lived together all this time. I really don't. They don't like each other. They just - well - Friday night he starts drinking and he really goes strong until Saturday night. He won't touch a drop all week, but every Friday night - " There was a slight pause. "And Mother doesn't say a word on Saturday. She doesn't dare. She knows it's the only time he'll tell her - he's brave enough then to do it and he doesn't care what he says. But that's the only time he will. Then she starts real early Sunday morning - she wakes him up on Sunday morning so that she can get an early start, and he really has a bad day. She won't let him forget it. And she goes back 20 years and brings it up to date. Twenty years! Once I asked him about it - what happened twenty years ago, but he just shrugged and said that it didn't matter now. She'd harped on it so long and wouldn't try to understand and he didn't want to talk about it." There was another pause. "But she always takes him back twenty years and then rehashes everything since then."

APPENDIX G

SAMPLES OF RAW DATA

Patient: Mrs. Betty B.

Number of Visit: 6

Date of Visit: Monday, April 11, 1960

Time of Visit: 3:30 P.M.

Length of Visit: 1 Hour, 45 Minutes

Family Members Present:

I was able to hear voices coming from the inside of the house and to see thatthe front door was open as I walked up the sidewalk toward the apartment. There were sounds of a child crying, and I could hear Betty's voice. She was speaking quite loudly, her voice was rather stridant and the words seemed short and sharp. As I looked through the screen door I could see Betty facing toward the bedroom. She was standing in the open doorway of the kitchen. The child who was crying said something, but I was unable to distinguish the words. Betty's words were enunciated quite sharply as she said, "Get your clothes changed now, Jean." I knocked lightly on the screen door, Betty turned, smiled and said, "Come in." Betty walked toward me as I entered. An ironing board was set up in the front room and an iron was resting on it. The iron appeared to be connected. However, there were no clothes in sight, either unpressed or pressed and I asked Betty if she was getting ready to iron. She said that it "became a case of necessity. After a while when you got down to where you were just wearing almost nothing, why you had to do something about it", and she laughed shortly. There was a frown on her forehead as she said this and as she laughed. I sat on the couch partially facing the kitchen, Betty walked to the kitchen door, looked through and then turned and walked back to the couch and sat down. There were about 3 or 4 feet between us on the couch and Betty sat partially facing in my direction with her arm resting on the back of the couch. Her face was serious, there were lines around her eyes and deep circles under her eyes. The sound of crying continued. Betty said, "Jean's really

had a bad day today."

A 3 year old boy came from the bedroom into the kitchen and climbed up on a straight-back chair beside the open kitchen door. He sat on the chair, looked at Betty and then at me but said nothing. His face was serious and there were tears in his eyes. He was wearing a little red jacket and red slacks. Betty looked at him and then turned to me and said, "Jean misunderstood what I told her. I told her Saturday that either Monday or Tuesday we'd go to town and buy their Easter shoes and then today when Leon was dropped off she really got upset. She thought we were supposed to go today, and I told her it would have to be Tuesday now." As she made these comments Betty's face was serious. There was a crease between her eyes and lines in her forehead. She appeared to me to be very concerned about the situation.

She said she was baby sitting for a short time with Leon while his mother went to work. His parents are friends of hers, his father owns some cafes and some days when they're short of help his mother goes to help out. She made the comment that she "just can't understand how they could live the way they do." She didn't think she could stand this, because they never see each other. Then she added "Of course, this is one thing about it - it's one way to be married and stay together - if you don't see each other you can't fight or argue ever, can you?" And she laughed as she made this comment. She again turned to Leon and asked to come toward her so she could take off his jacket. He climbed off the chair and came over to her. She slipped his jacket off of him, stood and walked over and laid it across the chair, then she walked back and sat down on the couch. Leon climbed up beside her on the couch and rested his head against her, she put her arm around him and hugged him gently and then turned back and sat down on the couch. Leon climbed up beside her on the couch and rested his head against her, she put her arm around him and hugged him gently and then turned back to face me.

She said that today had been a much better one, but that yesterday, Sunday, had really been bad all day long, that she had awakened feeling very depressed. She thought that one of the reasons was because she had run out of her thorazine. She'd gone over Sunday morning to try and have the prescription refilled, but was unable to refill it. He told her to come back a little bit later and he would contact the doctor, but it wasn't until 9:30 last night that she was able to get it, and even then he had not been able to contact the doctor. He had "finally refilled it"

for her. She had told him that she had been told to increase the medication and she felt that she had to have it before she'd be able to sleep last night. She said that she had had a much better night and had felt better all day long, that she felt the medication was very helpful to her and she didn't know how she would get along without it. She said that either she was going to have to resolve her problems or else she was going to have to take thorazine for the rest of her life, and this idea she didn't like very well.

Leon climbed off the couch and went out into the kitchen and then into the bedroom. He was only gone for a brief time and then he returned to the kitchen and again climbed up on the chair by the open kitchen door. Shirley came from the bedroom into the kitchen and opened the refrigerator door. Betty looked at her as she opened the door and turned again to me and said, "There it is again. Every five minutes they expect it to change and it never does. They keep expecting it to." Betty opened the freezer compartment and set out a wax paper container, opened the refrigerator and took out another container of similar size from the freezing compartment. She disappeared from view in the kitchen. Betty said something to her about giving some of this to Leon. Shirley said, "Oh, that was Jean's." Betty said nothing. Soon Shirley walked over carrying the container and a spoon and put the spoon into the container and then withdrew it and handed it to Leon. She then handed the container to Leon and left him with the container and the spoon in his left hand. Betty said to me, "Well, everything gets frozen around here. I take them over and buy them a malt, they eat a third of it and the rest of it goes in the freezer for three days. It's a lot more economical that way, but mine are the only kids I know that do this. They save it and save it. I can't understand it." She paused and then she made a comment that Jean saved everything. She said, "I don't know what I'm going to do about that girl. I can't understand it. She saves everything that she gets. She collects and collects. Anything that anybody throws away if she thinks it looks good she brings it home and puts it away somewhere. I just don't understand. Every paper she's ever made in school she's brought home and stored in there. She's got boxes full of stuff. I can't hurt her feelings. So I have to wait until she's not around, and I can't let her see me do this, but when she's not there why I'll get rid of a box of it when I see something that doesn't seem to be of very much use. I asked her one time what she saved it for and she said she didn't know, she just did and that was all. She really gets upset if she knows I'm

throwing anything away. She just cries and cries. I don't like to hurt her and I don't like to upset her, so I just have to wait until she isn't looking and then throw it out. She's the only child I know that collects everything there is to collect." She spoke these words quite softly so that they were not too audible. I was able to understand them clearly, but had the feeling that they could not be understood or overheard by anyone who was not in the very near vicinity.

Shirley came out of the bedroom and left the house. In about two minutes, Jean also went out of the house. As she started out of the kitchen door Betty called after her, "Jean, what are you wearing?" Jean said over her shoulder, "Just clothes." and went on out. Betty said, "Well, I can see it's purple and green, but I can't tell what else it is." Then she paused as Jean slammed the kitchen door and added, "That girl and the clothes she wears. Sometimes I wonder if she'll ever get so she's interested in the way she looks. She just, well, I hope she changes. I keep thinking maybe that now she's getting a little older but I wonder if she ever will. You know what she wants to be? She's the only girl I know that wants to be a garbage collector. She's going to be the only woman garbage collector in the whole world." I said, "Oh, has she changed her mind about being a nun?" And Betty said, "Oh, she's going to be the only garbage collecting nun in the whole world, but this is what she wants to be. Course now maybe she'll start changing a little bit. She wants some of those spool heels and nylons, no less," she paused and said, "She's not going to get them, and boy, this is going to be a blow. But I think spool heels will look all right with boby sox." She felt that nylons were too old still for Jean to be wearing, but she did feel that spool heels would look all right and she was going to get her some of these. She said that last year she had insisted on buying "little girl shoes" for Jean, and Jean had been very upset about this. She had cried all the way down the street. "I didn't know what to say to her. I kept feeling like saying, now stop it, I'm not beating you, I'm not being real mean to you, but she kept on crying and everyone was real upset." "People kept looking at her and you'd have thought I was really treating her mean. It took 2 or 3 days to get over the fact that she wasn't able to have shoes which she felt were older. I think that this year she can have some shoes that are a little bit more the kind she wants."

Leon climbed off the kitchen chair and came over and again sat beside Betty and Betty again put her arm around him, ran her fingers through his hair and smiled at him,

told him to come over so that she could tie his shoes. He came over, put his foot up on the couch and she tied first one shoe and then the other. He looked at me and I spoke to him but he did not respond. Betty said to him, "Can't you say hello?" He paused and then lowered his head, looked down at the couch and said, "Hello." in rather an abrupt, gruff voice.

Betty looked out the door and there was a large black dog outside the screen. She said, "Oh, he's brought Blackie home with him again. This is all we need, another dog. You know how many pups our dog had? Our dog, I call it ours. It's not ours, I don't know what we're going to do with the thing - seven pups. We've got 8 dogs here. And now he's got to bring another one home, there aren't enough. He has to feed it and sleep with it. My kid's the only boy I know that sleeps with a dog and talks to him, he even reads to him. I told him that I didn't think it was getting through, you know?, but this really upset him. He didn't like being told it wasn't getting through." She smiled as she was saying this, but her eyes were quite serious. There were lines around her eyes, and for a brief instant they appeared to be tearing somewhat. Several times, she mentioned all of the puppies that they had, and each time her face looked quite serious. Around her eyes the lines appeared, and there was a frown on her forehead, even though her lips might turn up in a smile as she spoke about them. She said, "I just don't know what we're going to do with them, what can you do with eight pups? I've got pups in back and neighbors in front. I don't know what to do with them all. I can't give them away. I've tried to do this. I don't know what to do with them." Later she said that she was planning on calling the dog catcher because she felt she could not take care of them all, but she knew the children were going to be extremely upset about this but she felt it was the only thing that she could do.

Jean came into the house and Betty said, "Jean, what are you wearing?" Jean replied, "Just some clothes." Betty said, "Take off my sweater right now." Her voice was deep but the words were short and sharp. Jean didn't say anything. Betty said, "I'll give you three seconds." Jean replied, "Well, what am I going to wear?" Betty said, "I don't care what you wear, but take off my sweater right now." Jean and Shirley went into the bedroom. In about one minute Betty said, "Has Jean taken off my sweater?" Shirley said, "No, she hasn't," and Betty said, "I said I'd give her three seconds." Jean then said, "Where's mine like it?" Betty: "I don't know." Jean went through the kitchen, out into the porch and then returned through the kitchen

carrying a turquoise colored sweater in her hand. She went into the bedroom and then about one minute later came out wearing the turquoise cardigan instead of the slip over she had on formerly.

Betty was watching her and said, "This is one thing I like about my kids. They always obey me and they just love to wear my clothes. I can't keep anything for myself. Not too long ago I washed all my sweaters and got them all clean and pressed, ready for me to wear. I went to work the next day after I had done all this and when I came home all three of them were wearing one, sleeves pushed up, globs of mud clinging from the sleeves, covered with dust - they really looked lovely." Then she added, "There's another thing I notice and that is that when I feel worse they do more - they obey me less. I don't like this. I don't like having this effect on my kids. It really bothers me that I'm doing this. I feel that I must be able to have discipline, and they can always seem to tell when I'm not feeling good and they just don't pay any attention to me. I noticed this yesterday. I was feeling terrible and they just didn't even listen or do a thing I told them to do. They just didn't pay any attention to me at all. This really bothers me. I don't think that this is good. It's wrong. It really is wrong for me to have this kind of effect on my children."

She turned and looked at Leon and then turned to me and smiled, "Oh, he's asleep." Then she turned back to Leon and gently lifted him into her arms. He opened his eyes and she said, "Let's go in and sleep on my bed." She stood and carried the child into the bedroom and laid him on her bed and said, "There, now you can have a good nap." She turned and came into the front room, and sat down again beside me on the couch.

She started talking about John, saying that an "interesting thing had happened." He had come and picked her up after work and said he had made great big plans for the rest of the week. I asked if by big plans she meant for her and him, and she said, "Yeah, this is what I mean. He's really got big plans and this is strange too. This is real strange. And you know? I already had plans made and this bothers me. This interferes with some things I was planning to do. This is a real important week for our church, and it's real important for my children because of school and everything. They participate and I feel like if they're participating, why I need to participate too. That they should see me - that I should at least make an effort and they should see me doing these things - I feel

that if something is going to be important to them and if I want it to be important to them - and I do - I think this is real necessary. Then I should be there taking part and they should see me doing this. Especially with Jimmy. He's going to be taking part on both Thursday and Friday, and Saturday, too, and I just feel like I should be attending this and I should participate, too. This seems like the right thing to do. Even if it's hard for me, I think I should do this, and now he's come with all of these big plans and this interferes." "And you know, I really kind of - well, didn't want this. Every time I start to pull away then he starts holding on somehow. He keeps doing things like this. I notice it every time I pull away a little. And you know, I still - today I felt nothing. Just absolutely nothing. It's as though I'm at an emotional standstill, or something. I just don't seem to have any kind of feelings, no feelings at all. And this is real strange. You know, this happened before, around Christmas time. I told him that I was so full of guilt I just felt like there was a real wall between the children and I didn't like this, especially at Christmas. This is such an important time and I felt so full of guilt and everything, and I felt like - well, maybe if I didn't see him for a couple of weeks. If I - for a period of time there was nothing between us, or nothing doing anyway - then maybe I'd feel better about this. And so I told him that I didn't want - that I felt that I must spend this time with my children, and that it would be better if we didn't see each other. And this is funny, too, because he told me he was going to be gone for a couple of weeks. I really chose a good time to do this, and it just seemed to work out." Then I asked if she had known that he was going to be gone before she told him this and she said that she didn't. I asked if she felt that it might have been partly because she had made this suggestion that he had planned this out of town trip and she said, "Oh, no." Then she paused and said, "Well, I don't think so. I think he already had this planned; but then, you know, he was only supposed to be gone 2 or 3 days and he was gone for the full two weeks. Nobody could understand it, he just disappeared. In fact everybody kept looking for him and nobody heard anything from him and he just seemed to have gone completely out of sight. They thought maybe he'd crashed in the mountains or something. Everybody thought he was gone and I got to a point where I just kept waiting and watching and I just didn't feel anything any more. And even when I saw him the first time I didn't feel anything any more. I just had no feelings at all. Ever since that time, I can't quite understand - this was the time I would have thought he would've wanted to stay home with his family.

Christmas is a real important time. He got home New Year's Eve. He was met at the airport by a lot of people; and then the next morning, when I would have thought he would have wanted to be with his children, he was over helping a neighbor or something. Then he wanted to spend time with me. He had to be told that he'd been missed. He - in fact, I didn't say what he wanted me to say so he told me what he wanted me to say, and I said it." I asked if she might be able to explain to him that she did have plans made for a part of the week that were important because they concerned her children. She said, "You know, I thought of that," and she smiled. Then she paused and said, "It's really hard. He just doesn't seem to accept somehow - but you know, I've got to get out of this situation. I just have to get out. But I don't think I have the strength to just do this myself. I don't know whether it's because I can't quite let him go or what it is, but I feel like I just can't just break this off. I don't think I have the strength somehow - to just completely stop this myself. I've tried, and if he'd go along with this - but I can't seem to really force the issue. And I just don't know what I'm going to do. I've got to do something, but I don't know what it's going to be." As we were talking Jimmy came into the house, leading the dog, Blackie. He said, "We've got to keep him in here. Penny's out in back there with those pups and he's apt to hurt them." Then he turned and walked out of the house. She laughed and said, "He's named our dog, <u>our</u> dog, humph, we call him ours - any how, he's named - this is the very same name as my mother's dog, Penny. Oh well, I don't want to tell him. She doesn't answer when he calls her this, but ignores it completely. It doesn't mean a thing to that dog. I don't want to disillusion him, so I let him go on calling her Penny. This is fine if this is what he wants to do. At least they've found out finally that it's a girl. For a while there they were going around saying, "He's had pups. You should have seen his pups.' But finally they've gotten to the point where they at least know that it's a female." She paused and said, "You know this had finally really brought it - I told you I was wondering when they, the children, would start asking about sex education, and growing up, and these kind of things and I was a little concerned. I felt something was wrong because they hadn't asked me anything for a long time and I wondered if I had done something or it was something I was doing that prevented this. But all of a sudden, when I was trying to get ready for work this morning - this was at 7:00 a.m. when I had ten minutes - they came and wanted to know how do the puppies get inside the stomach and then how do they get out again. Ten minutes, but anyhow I told them that this was something that took some time to explain, and

I would do this tonight and so we're going to talk about the puppies tonight." I asked if she had some feelings about doing this and that she felt fairly comfortable about it. She thought that she could use the pamphlets that I had taken her and that she would sort of explain to them about how the egg and the growth in the woman's stomach. She would tell them about the vaginaand then sort of compare this with the dog, and explain that it is somewhat similar. She said, "They really wonder about this, because the puppies were in there - she was big and all of a sudden she's skinny and there's no cut places or anything. They just can't understand how the pups came out." She didn't know when her next appointment was with Dr. J. because she had forgotten to ask him. She got up, went into the kitchen and looked into the oven. There was the frangrance of cooking food coming from the kitchen. She moved something in the oven, closed the oven door, and came back in and sat down on the couch beside me. Jimmy had left the house. The dog, Blackie, had gone to the back door and out through the back screen. There were a couple of yelps from the back and soon Jimmy again came into the house leading the dog, Blackie. He said, "We've got to keep this dog in the house. You can't let it out." He again went out through the front screen door. Soon the dog went to the back door and went out. Jean came in through the front door leading the dog and said, "You've got to keep this dog in the house. Penny's going to kill him. She really will. She's got those pups out there and you know how a mother dog is about her pups. She'll kill him if you let him out. You've got to keep him in the house." Betty didn't say anything. Jean went to the kitchen, closed the back door, and then went out the front door, closing it as she left the house. The dog stood by the front door looking toward it. A few minutes later he started scratching on the door a little bit. Betty made no movement toward him. He went to the back door. He was restless and moved back and forth through the house, from the front door to the back, making little whining sounds in his throat. Finally he started to yelp. Betty went to the front door, opened it and Blackie went outside. He was gone about 1 minute and Jean returned with the dog, carrying the dog's collar in her hands. She said, "You've got to keep this dog in the house. Penny will kill him. She really will kill him." Betty said, "Now don't say that again, Jean. You know it's not true." Jean said, "Well, you've got to keep the dog in the house." Betty said, "I can't keep him in the house." Jean: "I'll lock him in the bathroom." Jean went toward the bathroom door and opened it and said, "Here, Blackie." and Betty said, "Jean, you're not to put that dog in the bathroom." Jean called, "Here, Blackie." Betty said, "Jean, you cannot put that dog in the bathroom." Jean: "The dog won't stay in the house."

Betty: "Then you'd better take him home. Take the dog home, if he won't stay in the house and can't go outside." Jean said, "Well, I didn't bring him over." Betty: "Then call Jimmy and tell him to come and take the dog home, and give me that collar. We've got to put that on, he's got to wear the dog collar." Jean tried to put the dog collar on the dog, but was unable to get it unfastened. Betty said, "Give the collar to me." Jean handed the collar to Betty and she attempted to work with it a little bit. Then she said, "You're going to have to take the dog home and take the collar with you. Take Jimmy's bike." Jean said, "I didn't bring the dog over here." Betty replied, "You've got to take the dog back to Grandma's house, and take the collar. Ride Jimmy's bike, and leave the bike there. Do it right now!" Jean went out of the house, saying, "Well, if this dog gets killed it's not my fault. He won't go with me. He's not going to follow me. I don't know how I'm going to get him to follow me. It's not my fault if he gets killed. I hope he does get killed!" She slammed the screen door as she left. She went out and got on the bike, called to Blackie and rode off on the bike.

APPENDIX H

TABLE IX

TABULATION OF RAW DATE - FIRST RATING

Incidents	Categories												
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	N
1	XXXXX												
2	XXXXX												
3	XXX												
4	XXXX												
5	XXXX												
6			XXX				X			X			
7			XXXX							X			
8			XXXX							X			
9			XXXX							X			
10				XXXX									
11				XXXXX									
12		XX		XXX									
13			X	XXX									
14				XXXXX									
15				XXXXX									
16		X		XXXX									
17				XXXX									
18		X					XXXX						
19		XX	X						X				
20		X	X						X	X			
21		X	XX						X	X			
22		X	X						X	X			
23			XX						XX				
24		X	XX						X	X			
25		X					XXXX						
26		X					XXXX						
27		X					XXXX						
28		X					XXXX						
29			X				XXX						
30		X					X						X
31				XXX			X						
32		X					XXXX						
33			X			XX							
34							XXX						
35		XXX				XX							
36		X	X			XXX							
37			XX			XX	X						
38				X		X							X
39			X				XXXX						

*N.S. - Not significant

TABLE IX, CONTINUED

Incidents	Categories I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	N
40							XX						X
41		X					XXXX						
42			X				XXX						
43				X			XXXX						
44		X				XX							
45		X	XX			XX							
46			X			X							X
47			XX			X	X						
48		XX	X	XX									
49				XXXX				X					
50		X		XXX			X						
51				XXXX	X								
52				XXXX	X								
53				X			X	XXX					
54				XXXXX									
55		X					XXXX						
56		XXX					XX						
57		X		XX		X	X						
58			X	X		XX	X						
59			X	XXX			X						
60			X				X		X				
61			XX			XX			X				
62		X				XX	X						
63	XX					XX			X				
64				XX				X					
65				X			X	XX					
66				X				XX					
67				X				XX					
68		X	X	XXX									
69				XXXXX									
70				XXXX				X					
71		X		XXXX									
72		X	X	XXX									
73		X	X	XXX									
74				XXXXX									
75		XX				X			XX				
76				XX		X		X					
77		X				X	XXX						
78				X			X	XX					
79				XX			X	X					
80							X	XX					
81				XX			X	X					
82				XX			X						

*N.S. - Not significant

TABLE IX, CONTINUED

Incidents	Categories I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	N
83							X	XX					
84			XX			XX			X				
85		X	X			XX							
86			XXX			XX							
87							XXX						
88		XX	XX				X						
89		XXXX	X										
90		X	X				XXX						
91				XXXXX									
92		XX		X			XX						
93			XX		X	X							
94		X		X		X							
95			X				XXX						
96			X										XX
97		XX				X	X			X			
98		X	XX										
99			XXX			XX							
100	XX			X				X					
101		X						XXX					
102			XX			X			XX				
103		XX	XX				X						
104		XXX	X	X									
105		XXX	XX										
106		XXXX	X										
107		XXX	XX										
108	XXXXX												
109	XXXXX												
110		X		X			X	X					
111		XX	XX			X							
112		XXX	X		X								
113		XXXX	X										
114		XXX	X		X								
115				XXXXX									
116		X	X		X								
117		X	X		XX		X						
118				X	XXXX								
119				X	XXX								
120		X	XX	X	X								
121		X	XXXX										
122	XXXXX												
123				X	XXXX	X							
124			X		XXX								
125			XX			XXX							

*N. S. - Not significant

TABLE IX, CONTINUED

Incidents	Categories I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	N
126			X				XX						
127		X	XX			X	X						
128			XXX	X	X								
129				X	XXXX								
130				X	XXXX								
131				X	XXX								
132				X	XXXX								
133				X	XXXX								
134		X	XXX			X							
135		XXXX	X										
136				X	XXX								
137		X		X	XXX								
138		X	XXX			X							
139					X			X					X
140				X	XXXX								
141		X	XXX			X							
142		X	X				XXX						
143				X	XXXX								
144		XXX	X		X								
145				X	XXXX								
146			X	X	XXX								
147				X	XXXX								
148			XX		X				XX				
149			XXXX		X								
150					XXX								
151		XXX	X		X								
152			X		XXX	X							
153				X	XXXX								
154				X	XXXX								
155			XXXX										
156				X	XXXX								
157			XX			XXX							
158			X	X	XXX								
159					XXXX								
160		X	XX			X			X				
161			X		X								X
162			XXX			XX							
163		XX	XX			X							
164				X	XX								
165		X	XX						X				
166				X	XXXX								
167			XXX		XX								

*N. S. - Not Significant

TABLE IX, CONTINUED

Incidents	Categories I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	N
168		XXX	XX										
169			X			XX							
170				X	XX								
171		XX	XX			X							
172			X						XX				
173			X			XX							
174		X	XXXX										
175			XX				XX						
176				X	XXXX								
177				XXXX				X					
178			XXXX		X								
179			X	XX					X				
180		X	X		XX				X				
181							XX						X
182		XX	XXX										
183		X	XXX			X							
184		X	XX				X						
185			XXX										
186		X	XXX			X							
187					XX								X
188		XX	XXX										
189		X				XXX							
190			X	XXX	X								
191		X	XXX		X								
192		X	X		X	X				X			
193			XX	XXX									
194			XXXX			X							
195		XX				XXX							
196	XXXXX												
197		XX	X			XX							
198					XXX				X				
199		X	XXXX										
200	XX	X											
201	XXXX	X											
202		X		XXXX									
203		XXX	X						X				
204		X		XXXX									
205		X		X		X							
206		X		XX				XX					
207		X						XX					
208		X		XX				X					
209		X						XXX					
210		X		X				XXX					
211		X	X	XXX									
212		X		XXX				X					

* N.S. - Not Significant

TABLE X

TABULATION OF RAW DATE - SECOND RATING

Incidents	Categories I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	N N
1	XXX												
2	XXX												
3	XXX												
4	XXX												
5	XXX												
6		X	XX										
7			XXX										
8		XX					X						
9	X	X	X										
10				XXX									
11				XXX									
12		XX		X									
13				XX				X					
14				XXX									
15				XXX									
16			X	XX									
17			XX			X							
18							XX			X			
19			XXX										
20													
21			XXX										
22													
23									XX		X		
24		X	XX										
25									XXX				
26							XXX						
27		X					XX						
28		X					XX						
29		X					XX						
30													
31				X			XX						
32							XXX						
33							XX			X			
34							XXX						
35		X				XX							
36		XX	X		X	X							
37		X											
38													
39		X					XX						
40													

'N.A. - No Agreement on First Rating
*N.S. - Not Significant on First Rating

TABLE X, CONTINUED

Incidents	Categories I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	N
41		XX					X						
42		X					XX						
43		X					XX						
44		X	X	X									N
45		XX	X										N
46													N
47												XXX	N
48			X	X					X				N
49		X		X	X								
50				XXX									
51				XXX									
52				XXX									
53								XXX					
54			X	X							X		
55		X					XX						
56			XX								X		
57				XXX									N
58		X				XX							N
59				XX		X							
60													N
61									XX		X		N
62						X	X				X		N
63			X			X					X		N
64								XXX					N
65		X						XX					N
66								XXX					N
67								XXX					N
68			XX					X					
69			XX	X									
70								XXX					
71		X	X								X		
72		X	X	X									
73		X	X	X									
74			XX	X									
75						X			XX				N
76				XXX									N
77			X				XX						
78								XXX					N
79				X				XX					N
80				X				XX					N
81				X				XX					N
82				X				XX					N
83				X				XX					N

'N. A. - No Agreement on First Rating
*N. S. - Not Significant on First Rating

TABLE X, CONTINUED

Incidents	Categories												N
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	N
84									XX		X		N
85		X	X			X							N
86						XXX							
87						X	XX						
88		X	XX										N
89		XX	X										
90		X					XX						
91				XXX									
92				X			XX						N
93					X	XX							N
94													N
95							XXX						
96													N
97													N
98										XXX			N
99		X	X							X			
100						XX				X			
101								XXX					
102						X			XX				N
103		XXX											N
104			XX								X		
105		X	X								X		
106		XXX											
107			XXX										
108	XXX												
109	XXX												
110													N
111			XXX										N
112		X	X								X		
113			XXX										
114		X	X								X		
115				XX			X						
116													N
117					XXX								N
118					XXX								
119					XXX								
120					XXX								N
121		X	X	X									
122	XXX												
123					XXX								
124					XXX								
125						XXX							
126			X				XX						N

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TABLE X, CONTINUED

Incidents	Categories												N
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	N
127			XXX										N
128			XX		X								
129					XXX								
130					XXX								
131					XX			X					
132					XXX								
133					XXX								
134			XX			X							
135			XXX										
136					XXX								
137			X		XX								
138				X		XX							
139													N
140					XXX								
141		XX				X							
142		X	X				X						
143					XXX								
144			X						XX				
145			X		XX								
146					XXX								
147					XXX								
148		X							X		X		N
149		X	X			X							
150					X							XX	
151			XXX										
152					XX	X							
153			X		XX								
154					XX						X		
155				XX				X					
156					XXX								
157			XX			X							
158					XXX								
159					XXX								
160		X	X		X								N
161													N
162		X				XX							
163			X		X						X		N
164					XXX								N
165		XX				X							N
166			X		X							X	
167			XX		X								
168		X	X								X		
169						XXX							N

'N.A. - No Agreement on First Rating
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TABLE X, CONTINUED

Incidents	Categories I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
170					XXX							
171		X				X					X	
172									XXX			
173						XX			X			
174		X	XX									
175							XXX					
176					XXX							
177				XXX								
178					XXX							
179				XXX								
180					XXX							
181												
182	X		X								X	
183		XX									X	
184		X	XX									
185						XX					X	
186		X	XX									
187												
188		X	XX									
189						XXX						
190		XX		X								
191		XX	X									
192		X				X				X		
193		XX	X									
194		X	XX									
195						XX		X				
196	XXX											
197	XX					X						
198					XXX							
199		XX									X	
200	XXX											
201	XXX											
202				XX				X				
203	XX		X									
204								X			XX	
205												
206				XX				X				
207								XX			X	
208				XX							X	
209								XXX				
210							X					XX
211				X								XX
212				X				XX				

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